REPRODUCTIVE HEALTH PROGRAMS FOR ADOLESCENTS

The cases of Buenos Aires, México D.F. and São Paulo

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REPRODUCTIVE HEALTH PROGRAMS FOR ADOLESCENTS

The cases of Buenos Aires, México D.F. and São Paulo

CEDES, Buenos Aires, Argentina
El Colegio de México, México D.F., México
NEPO/UNICAMP, Campinas, Brazil

CASE STUDIES REPORT

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SUMMARY

This report contains results from a research project on the main public programs in the field of adolescent reproductive health in Buenos Aires, Sao Paulo and México D.F. This study was conducted by the Consorcio Latinoamericano de Programas en Salud Reproductiva y Sexualidad (Consortium of Programs in Reproductive Health and Sexuality in Latin America), a group composed of multidisciplinary research teams based at Centro de Estudios de Estado y Sociedad (CEDES, Buenos Aires, Argentina), El Colegio de México (México DF, México) and Nucleo de Estudos de Populaçao (NEPO, Campinas, Brazil), under the coordination of CEDES.

Its goal was to describe and analyze these programs in order to recommend strategies to better meet the reproductive health needs and expectations of adolescents[1]. Expected outcomes were: a) the identification of political and institutional barriers that curtail the development and growth of adolescent reproductive health programs and services and b) the analysis of health care providers' and users' perspectives on the performance of programs and services.

Case studies were constructed using a variety of sources and techniques to produce:

a)A socio-demographic profile and an epidemiological diagnosis of the target population that provided a context for the programs and services analyzed;

b) An analysis of programs' documents that allowed us to assess their adequacy to the Cairo and Beijing guidelines and commitments;

c) An assessment of the perspectives of public health officials, technical staff and service providers regarding program implementation and the barriers and facilitators affecting the development of programs. A total of twelve semi-structured interviews with public health officials and technical staff (five in Buenos Aires, three in México D.F., and four in Sao Paulo) and thirty-five semi-structured interviews with health providers (sixteen in Buenos Aires, nine in México D.F. and ten in Sao Paulo) were carried out;

d)An assessment of adolescents' expectations regarding the characteristics of programs and services. A total of 91 adolescent health service users were interviewed (31 in Buenos Aires, 30 in México D.F., and 30 in Sao Paulo).

On the basis of the three case studies a comparative analysis was made to identify contrasts and similarities and point out their possible causes. This analysis includes a

comparison of the epidemiological data, of programs documents and the political contexts in which they were issued and of research results of the fieldwork conducted in the three sites.

The study reveals that, despite their differences (e.g. in origin, scale, focus, etc) the programs and services analyzed face some common problems. Social, cultural and religious barriers still affect the promotion of adolescent sexual and reproductive health rights in the three sites. Programs implementation and growth are also affected by the consequences of structural adjustment policies (higher number of population with unmet basic needs and/or without medical coverage due to increasing rates of unemployment) and of health sector reform (e.g. cutbacks in health budgets, staff reductions, shortage of supplies, etc.).

Positive aspects to be highlighted are that health teams are highly motivated and committed to providing services to the target population and that in general the interviewed adolescents showed satisfaction with health care The main criticisms are related to long waiting hours, the method for assigning turns and/or the facilities. The relationship with care providers is evaluated in a very positive way in most of the cases: adolescents show satisfaction for the treatment and explanations received, and for the service being free of charge or being accessible.

Findings indicate the need to increase programs resources and to train or re-train health professionals in gender/rights issues and to enhance their abilities to deal with induced abortion, dual protection, emergency contraception, violence and substance abuse. Program monitoring and evaluation, with the participation of adolescents, are pending tasks which could contribute to strengthen the programs and reorient actions.

[1] Following the World Health Organization's (WHO) definition of adolescence, we considered those who are between ages 10 and 19 as our study population.

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I. GENERAL INTRODUCTION

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1. Introduction

This report contains the results of a research project on the main public programs in the field of adolescent reproductive health in Buenos Aires, Sao Paulo and México DF. This study was conducted by the Consorcio Latinoamericano de Programas en Salud Reproductiva y Sexualidad (Consortium of Programs in Reproductive Health and Sexuality in Latin America), a group composed of multidisciplinary research teams based at Centro de Estudios de Estado y Sociedad (CEDES, Buenos Aires, Argentina), El Colegio de México (México D.F., México) and Nucleo de Estudos de Populaçao (NEPO, Campinas, Brazil), under the coordination of CEDES.

The goal of this project was to describe and analyze these programs in order to recommend strategies to better meet the reproductive health needs and expectations of adolescents[2]. Expected outcomes were: a) the identification of political and institutional barriers that curtail the development and growth of adolescent reproductive health programs and services and b) the analysis of health care providers' and users' perspectives on the performance of programs and services.

Case studies were constructed using a variety of sources and techniques to produce the following information:

a) A socio-demographic profile and an epidemiological diagnosis of the target population based on data from secondary sources and special tabulations produced for the purpose of this study. This information provided a context for the programs and services analyzed.

b) An analysis of the documents and written materials of the selected programs, that allowed us to assess their adequacy to the Cairo and Beijing guidelines and commitments.

c) An assessment of the perspectives of public health officials, technical staff and service providers regarding program implementation and the barriers (political, institutional, etc) and facilitators affecting programs' development. A total of twelve semi-structured interviews with public health officials and technical staff (five in Buenos Aires, three in México D.F., and four in Sao Paulo) and thirty-five semi-structured interviews with health providers (sixteen in Buenos Aires, nine in México D.F. and ten in Sao Paulo) were carried out.

[2] Following the World Health Organization's (WHO) definition of adolescence, we considered those who are between ages 10 and 19 as our study population.

d) An assessment of adolescents' expectations regarding the characteristics of programs and services. A total of 91 adolescent health service users were interviewed (31 in Buenos Aires, 30 in México D.F., and 30 in Sao Paulo).

On the basis of the three case studies a comparative analysis was made to identify contrasts and similarities and point out their possible causes. This analysis includes a comparison of the epidemiological data, programs documents and political contexts and of research results of the fieldwork conducted in the three sites (see Chapter V).

Finally it is worth mentioning that one workshop was conducted in each site to disseminate research findings among public officials, technical staff, health care providers, NGOs and academics working in the field of adolescent reproductive health.

2. About the criteria for selection of programs and services

As anticipated in the research proposal, the status of adolescent health programs differs to some extent among the three sites. In Buenos Aires, where there is a long tradition of providing health care services to adolescents in public hospitals, there is formally no program at the City's Health Secretariat. Thus, in this case, the document analyzed is the National Plan for the Integral Health of the Adolescent. On the contrary, at the other two sites (México DF and Sao Paulo) there is more than one program. As explained in these case studies, the most representative and/or interesting ones were selected for study. Consequently there are also some differences among the services chosen for fieldwork in each site that are worth mentioning.

One of such differences is related to the type of service analyzed: a health care center and an outpatients clinic[3] in Sao Paulo; a primary health care module and an educational program of a hospital specialized in obstetrics and gynecology in México D.F.; and Adolescents Services in public hospitals in Buenos Aires.

There is also a certain diversity among the selected programs and services regarding the main focus of health care: reproductive health in some cases and holistic health[4] in others. Therefore, for example, the term “reproductive health” appears only in the Mexican case while the two Brazilian programs analyzed and the Argentine National Plan use terms such as “adolescent health" or "adolescent integral health". However, in

[3] This type of health care facility offers a broader array of services than a health care center but it does not handle the most complex patients (these are referred to hospitals). In the ambulatory care facility included in the study, a general doctor (specialized in public health) sees the patients in the first visit and decides whether or not they have to be seen by a specialist like a gynecologist.

[4] Health care that responds to the adolescent as a person, rather than focusing exclusively on specific problems (UNFPA-ICPD + 5, .1998, p. 23).

the case of PROSAD (Sao Paulo) sexuality and reproductive health are explicitly considered as priority targets for intervention.

Another difference worth remarking is the relative weight of the provision of health care vis a vis the development of educational activities. The majority of the programs and services analyzed are basically directed towards the provision of health care and psychological consultation. The PREA (México D.F.) is the exception since it is fundamentally an educational program despite the fact that it provides medical and psychological care and that it is carried out within a hospital specialized in obstetrics and gynecology.

Regarding the user population, two out of the six services included in the study are directed exclusively to women since they belong to Ob-Gyn Services, while the rest are theoretically directed towards adolescents from both sexes.

Differences also exist regarding the volume of population served by the selected services and the composition of the professional health care teams. In the cases of México D.F. and Sao Paulo the health care teams include general physicians, psychologists and nurses, while the Adolescents Services studied in Buenos Aires include in addition pediatricians and social workers.

We were aware that even when the diversity of situations could elicit some difficulties at the time of the comparative analysis, it was our priority to choose typical or representative cases from each site and also to illustrate the patchwork of situations which make up the current supply of reproductive health services for adolescents in each city and in the region as a whole.

3. About the contents of the report

This report consists of five chapters:

I. Introduction

II. Buenos Aires Case Study

III. México D.F. Case Study

IV. Sao Paulo Case Study

V. Comparative Analysis.

This Introduction includes a section on the principles and strategic objectives of the Cairo and Beijing Platforms of Action regarding adolescent reproductive health. This description provides a framework for the case studies, since one of the goals of this project

was to assess the adequacy of existing reproductive health programs for adolescents to the Cairo and Beijing guidelines.

Case studies (Chapters II, III and IV) include the following sections:

- Institutional context
- Characteristics of the health services selected for in-depth study
- Socio-demographic and epidemiological characteristics of adolescent population;
- Adolescent health from the providers' perspective
- Health care from users' perspectives
- Final Considerations.

Each case study also contains a brief description of fieldwork, and two annexes : one containing the socio-demographic and epidemiological data and another one with socio-demographic information on interviewees (public officials, health providers and service users).

Chapter V contains the comparative analysis of cases. It points out key issues identified through the analysis of epidemiological data, assesses the adequacy of programs and services to Cairo and Beijing guidelines and provides recommendations for program/service development and improvement. Finally, the interview guidelines and informed consent forms that were used in the three sites are enclosed in a General Annex.

4. Cairo and Beijing documents

Adolescent sexual and reproductive health concerns were the focus of the debate and consensus in both international conferences. In the Programme of Action of ICPD (U.N., 1994), there is a special section devoted to Adolescents (E) in Chapter VII, Reproductive rights and reproductive health. The Platform for Action of the Fourth World Conference on Women (UN, 1995) includes references to adolescent reproductive health and programs in Sections C (Women and Health) and L (The girl-child). It should be noted that in both documents the “adolescent issue” is part of sections to which the Holy See expressed a general reservation. This fact can be considered an indication of the controversial nature of the issue.

Section E of ICPD’ s document begins by acknowledging that “the reproductive health needs of adolescents as a group have been largely ignored to date by existing reproductive health services”. It thus proposes “The response of societies to the reproductive health needs of adolescents should be based on information that helps them

attain a level of maturity required to make responsible decisions. In particular, information and services should be made available to adolescents to help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility" (7.41).

Special emphasis is given in the document to:

a) male responsibility in sexuality and fertility: young men need to be educated to “respect women’s self determination and to share responsibility with women in matters of sexuality and reproduction” (7.41).
b) the prevention of adolescent pregnancy: “Motherhood at a very young age entails a risk of maternal death that is much greater than average, and the children of young mothers have higher levels of morbidity and mortality. Early child-bearing continues to be an impediment to improvements in the educational, economic and social status of women in all parts of the world. Overall for young women, early marriage and early motherhood can severely curtail educational and employment opportunities and are likely to have a long-term, adverse impact on their and their children’s quality of life”.

It should be noted that even though the document acknowledges that “in both developed and developing countries, adolescents faced with few apparent life choices have little incentive to avoid pregnancy and child-bearing” (7.42), still the general goal is “to substantially reduce **all** adolescent pregnancies” (7.44 b, our emphasis). Thus, in the document, “adolescent pregnancy” is treated as an homogeneous phenomenon (without distinguishing, for instance, between the situation of younger and older women in that age group) and basically as a “problem”.

The strategy proposed to address adolescent sexual and reproductive health issues (including unwanted pregnancy, unsafe abortion, STDs and HIV/AIDS) is twofold: “the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence and the provision of appropriate services and counseling specifically suitable for that age group” (7.44).

We will now focus on the considerations made by ICPD’s Programme of Action about the profile of programmes for adolescents, which is the main focus of our analysis.

Paragraph 7.45 states that “Recognizing the rights, duties and responsibilities of parents and other persons legally responsible for adolescents to provide, in a manner consistent with the evolving capacities of the adolescent, appropriate direction and guidance in sexual and reproductive matters, countries must ensure that the programmes and attitudes of health-care providers do not restrict the access of adolescents to

appropriate services and the information they need, including information on sexually transmitted diseases and sexual abuse. In doing so, and in order to, *inter alia*, address sexual abuse, these services must safeguard the rights of adolescents to privacy, confidentiality and, respect and informed consent, respecting cultural values and religious beliefs. In this context, countries should, where appropriate, remove legal, regulatory and social barriers to reproductive health information and care for adolescents". In addition, the document lists the areas in which programmes should provide education and counseling to adolescents: gender relations and equality, violence against adolescents, responsible sexual behavior, responsible family-planning practice, family life, reproductive health, STDs, HIV infection and AIDS prevention (7.47).

Finally, the document indicates that in order to be effective, programs need to "secure the full involvement of adolescents in identifying their reproductive and sexual health needs and in designing programs that respond to those needs" (7.43).

Also, programs are made responsible for training "all who are in a position to provide guidance to adolescents concerning responsible sexual and reproductive behaviour": parents and families, communities, religious institutions, schools, the mass media and peer groups. Special reference is made to the need to "educate parents" to enable them to "comply better with their educational duties to support the process of maturation of their children, particularly in the areas of sexual behaviour and reproductive health" (7.48).

Similar ideas are expressed in the Beijing Platform for Action. Paragrah 93 states that "Counseling and access to sexual and reproductive health information for adolescents are still inadequate or lacking completely, and a young woman's right to privacy, confidentiality, respect and informed consent is often not considered. Adolescent girls are both biologically and psychosocially more vulnerable than boys to sexual abuse, violence and prostitution, and to the consequences of unprotected and premature sexual relations. The trend towards early sexual experience, combined with a lack of information and services, increases the risk of unwanted and too early pregnancy, HIV infection and other sexually transmitted diseases, as well as unsafe abortions. Early child-bearing continues to be an impediment to improvements in the educational, economic and social status of women in all parts of the world. Overall, for young women early marriage and early motherhood can severely curtail educational and employment opportunities and are likely to have a long-term, adverse impact on the quality of their lives and the lives of their

children. Young men are often not educated to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction".

Actions to be taken to strengthen preventive programs that promote women's health (Strategic Objective C.2) by governments in cooperation with NGOs, the mass media, the private sector and relevant international organizations, as appropriate, include: "Recognize the specific needs of adolescents and implement specific appropriate programs, such as education and information on sexual and reproductive health issues and on sexually transmitted diseases, including HIV/AIDS, taking into account the rights of the child and the responsibilities, rights and duties of parents as stated in paragraph 107 (e) above"[5] (107.g). "Meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality" is also an action to be taken to meet Strategic Objective C.3 (Undertake gender-sensitive initiatives that address STDs, HIV/AIDS and sexual and reproductive health issues).

References to adolescent health and programmes can also be found in section L (The girl-child), which basically draws on paragraph 7.3 of ICPD's Programme of Action (see above). In addition, paragraph 273 states that "In addressing issues concerning children and youth, Governments should promote an active and visible policy of mainstreaming a gender perspective into all policies and programmes so that before decisions are taken, an analysis is made of the effects on girls and boys, respectively".

Finally, some key issues related to our topic are revisited in relation to Strategic objective L.5. (Eliminate discrimination against girls in health and nutrition). Governments and international and non-governmental organizations are encouraged to "raise awareness of the health dangers and other problems connected with early pregnancies" (281.b); "Strengthen and reorient health education and health services, particularly primary health care programmes, including sexual and reproductive health" (281.c) and "Emphasize the role and responsibility of adolescents in sexual and reproductive health and behaviour through the provision of appropriate services and counseling, as discussed in paragraph 267" (281.g).

In summary, recent international agreements have given a strong voice to the rights of adolescents to reproductive health information and care (UNFPA-ICPD + 5;

[5] "...in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the Convention on the Rights of the Child, and in conformity with the Convention on the Elimination of All Forms of Discrimination against Women; ensure that in all actions concerning children the best interests of the child are a primary consideration" (Platform for Action and the Beijing Declaration, UN, p. 67).

1998, p. 4), and have highlighted that services should safeguard their right to privacy, confidentiality and informed consent. Still, some ambiguities and tensions can be detected in the text. Paraphrasing Arilha (1999, p. 41), the Platforms for Action resemble "quilts" to some extent. As Lassonde (1997) points out, consensus at ICPD was reached due to the adoption of a very particular syntax, where antithetic positions are juxtaposed and vague and imprecise concepts and expressions (male responsibility and sustainable development, for instance) coexist in the text alongside with expressions that restrict the scope of recommendations ("as appropriate", "depending on the case", etc.). (cited in Arilha, 1999, p. 43, our translation). The juxtaposition of different languages or perspectives is also evident in the sections on adolescent sexual and reproductive health and rights. For instance, the prevention of adolescent pregnancy is simultaneously justified in terms of public health, women' right to self determination and demographic needs ("to slow the momentum of population growth", paragraph 7.41). This section also contains several imprecise expressions (for instance, "appropriate direction and guidance in sexual and reproductive matters") and does not explicitly acknowledge that there might be conflicts between the rights of adolescents to privacy and confidentiality and the rights of parents and other persons legally responsible for adolescents. In addition, the fact that the document recognizes that parents need to be educated regarding sexual behaviour and reproductive health and that communication between parents and children needs to be improved is, to some extent, contradictory with the fact that parents are expected to "provide appropriate guidance in sexual and reproductive matters". Finally, a special mention must be noted to the great emphasis the document places on the concept of individual responsibility in relation to sexuality and reproduction and to the determining role attributed to information as a means of enhancing such responsibility[6]. This perspective greatly contrasts with the evidence based on working with adolescents in the sense that fostering a sexual subject, an individual capable of being the regulating agent of his/her own sexual life, is a complex process that requires something more than information and appeals to responsibility (Paiva, 1996).

The case studies that follow provide information on programs in the three cities in Latin America designed to improve reproductive health of adolescents.

[6] The word responsibility (and similar ones like "responsible") is mentioned 119 times in the Cairo document and 38 times in Chapter VII. (Arilha, 1999).

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II. CASE STUDY

Adolescent Reproductive Health Programs in Buenos Aires, Argentina

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Chapter 1. Institutional Context

1.1. General considerations on the health system

In many respects Argentina has a highly developed health system, particularly by developing country standards. Life expectancy at birth is 71, infant mortality has fallen by 45% since 1970, and nearly 80% of young children are vaccinated. However a number of Argentina´s health indicators are worse than those of other middle-income countries in the region with lower per capita income and lower spending on health. For example Chile, Costa Rica and Uruguay all have higher life expectancy and significantly lower infant mortality rates, ranging from 14 to 20, compared to Argentina´s 29 per 1000 live births. Also, maternal mortality and malnutrition are unacceptably high, especially in the Northern provinces and low-income periurban areas. Yet Argentina´s health expenditure is much higher at US$ 500 than in Chile (US$ 250), Costa Rica (US$ 160) or Uruguay (US$ 124).

Health care delivery is broadly shared by public and private providers and entities tied to the statutory health funds *(obras sociales)*. There are about 300 statutory national health funds covering active workers and their families and 24 provincial health funds -one for each province- which cover public sector employees and their dependents. There is also a health fund for about 4 million retired, disabled and pensioned persons and their families (PAMI). During the 1970s and beginning of the 1980s, it was estimated that 70% of the population had coverage from either social insurance or private insurances. The remaining 30% relied mainly on the public hospital system, which generally provides free care. According to the figures provided by INDEC (National Institute for Statistics and Census), in 1999 the population with a national health fund, including PAMI, totals 15.8 millions; in 1990 the total population covered by these funds was about 18 millions (*Clarín*, September 26, 1999, p. 30).

This fall is due to the increase of unemployment (from a rate of 6-7% at the beginning of the 90s to 16.1% in August 1998) and to a rise in black market employment. As a result of this situation, an increasing number of those who no longer are affiliated to any welfare fund go to public hospitals. Official data shows a significant increase of the medical consultations and admissions in public hospitals. According to the City of Buenos Aires' Health Secretariat, since 1992 there has been a constant increase in medical consultations by unemployed people and "the new poor".

The City of Buenos Aires has the highest budget for health expenditure of all national districts. It is one of the jurisdictions with the highest number of hospital beds and the most complete high technology medical services in the country. It has 180 health care

facilities, 29 of which depend on the city's Health Secretariat (13 acute general hospitals, 2 child hospitals and 13 specialized hospitals). There are also 30 primary health care centers and recently a health care delivery system based on family doctors was implemented free of charge. In 1995, the city had 23,052 hospital beds, which represented 15% of bed capacity in the country. On average, 60% of consultations in public hospitals were done for city residents and the rest were mainly for people living in different districts of Greater Buenos Aires. Excluding healthy newborns, discharges from hospitals of the city's Health Secretariat amounted to 157,485 in 1995. 9.9% of these discharges corresponded to patients aged 10-19, 67% of whom were females (Gobierno de la Ciudad de Buenos Aires, Secretaría de Salud, 1998).

The country´s health financing system is in crisis. Even though total health expenditures are near US$ 20 billion a year or more than 7% of the GDP, the two main public pillars of the system –social security-based health insurance and provincial government health expenditures– have incurred large deficits in recent years, contributing importantly to Argentina´s overall fiscal problems. Public sector hospital service delivery capacity and quality has been seriously eroded by inadequate financing and maintenance, obsolete equipment and management weaknesses and lack of accountability and authority. As a measure to resolve this crisis some provinces are beginning to create autonomous public hospitals, which they hope will be better managed and will recover a larger share of their expenditures from those able to pay.

1.2. Public policies regarding adolescents

The national government has no explicit policies regarding adolescents and there is no program on adolescent health or reproductive health. However there is a National Plan for the Integral Health of the Adolescent that contains broad guidelines for potential programs to be designed and implemented at the provincial level. This Plan dates back to 1993 and acknowledges the influence of the PAHO (Pan American Health Organization) framework for integral health programs for adolescents.

Previously, in 1991, the Coordinating Committe on Public Policies for Women had signed an agreement with the Health Secretariat to develop joint actions with the Maternal and Child Health Program to "formulate and implement public policies to help adolescent women to prevent unwanted pregnancies and to give integral protection to adolescent mothers" (Consejo Coordinador de Políticas Públicas para la Mujer, our translation). Actually, only some small grants were given to provinces to develop local situation reports

on the issue of adolescent pregnancy, but the announced policy was never implemented (Gogna, 1996).

The reluctance of the national government to address the issue of adolescent reproductive health is basically related to its ideological position and the strong support given by President Menem to the views held by the catholic church (see 1.5).

Some key informants have also explained the absence of adolescent health programs on the basis of economics. Given scarce resources, Services Directors tend to give priority to expenditures in maternal and child care in order to accomplish the goals established by government for the year 2000. Furthermore adolescent health is not considered a prestigious speciality, due to its low profitability. According to one respondent:

"Adolescents do not get ill, do not die, except for accidents, and require consideration, respect and plenty of time while being provided health care" (Director of the National Adolescent Plan at the Ministry of Health and Social Welfare, male).

Despite its reluctance to implement programs and services to provide reproductive health care to adolescents, in 1993 the national government endorsed a PAHO resolution (approved by the Executive Board at the XXXVI meeting) that encouraged governments to develop or strengthen national initiatives to promote adolescent health. Thus, a few months later, the National Plan for the Integral Health of the Adolescent was launched.

The National Plan's purpose was to "promote and protect the health of adolescents through a growing coverage in the quality and quantity of services" (MSAS,1993). According to an interviewed public official, the National Plan

"... focuses on health as a social product, in which education, work and life conditions come together. Integral health was conceived from an intersectorial and interdisciplinary approach". (Director of the National Adolescent Plan at the Ministry of Health and Social Welfare, male).

According to one of its authors,

"the Plan intended to generate a space for adolescents and set up the guidelines for adolescent integral health. It is a political statement rather than an action plan. It was supposed to allow the development of multiple programs in different states and jurisdictions" (Coordinator of Obstetric Area *of the Adolescent Service at the University Hospital Gral San Martín, female).*

Despite the government's intentions, to some extent, the existence of the National Plan acknowledged adolescents as a population with specific needs and interests entitled to receive information and services that would enable them to "deal responsibly with their sexuality" (MSAS, 1993, p. 27).

Under the umbrella of the National Plan, working groups on adolescence, services for adolescents or adolescents ambulatory care rooms were developed or legitimised in different jurisdictions, either in connection with the Maternal and Child Program or with the Maternal, Child and Youth Program. At present, 20 out of 24 provinces have some kind of experience with adolescent programs.

We now focus on the situation in the city of Buenos Aires[7]. Even though health care to adolescents is provided in the majority of its 15 public hospitals and in many primary health care centers, the local government does not have an integral health program or a reproductive health program for adolescents.

However, since 1988 the city has a family planning program, called the Responsible Procreation Program (PPR) that includes young people ages 15-19 as part of its target population. The PPR main focus is family planning. We decided not to include it in our study because we preferred to include health care facilities which offered a broader range of services besides contraception.

Despite the lack of a specific program for adolescents at the City's Health Secretariat, in the recent past there have been informal contacts among teams working in adolescent health, as referred by key informants from the city administration (former Director of the Responsible Procreation Program, male). In 1993 some groups providing health care to adolescents formed an Adolescent Network. Its goal was to allow the exchange of experiences regarding achievements and difficulties, to develop complementary actions between groups, and to organize training workshops and multi-centered research projects, among other activities.

The Adolescent Network operated quite regularly until 1997, when due to a series of administrative and political changes, its members stopped meeting. The problem was that the professionals specializing in adolescents and the pediatricians in the network competed for delivering health care to that age group. In fact, such internal debate resulted in the inclusion of the Adolescent Network within the Pediatrics Network.

[7] In 1994 the Argentine Parliament amended the National Constitution making the City of Buenos Aires -which previously belonged to the Federal Government- an autonomous jurisdiction. Since 1996 the City has its own constitution and its Mayor is elected by the population (before that, he was appointed by the President). Since then, the city government has been held by the Radical Party (a century-old political party, holding a social-democratic ideology). It should be remembered that from 1989-99 the country was ruled by President Menem, from the Peronist Party.

In 1996, a team of professionals, most of them members of the network, prepared a proposal for a Program of Integral[8] Medical Care for Adolescents for the Buenos Aires City Government. Based on a profile of the adolescent population and its health problems it provided guidelines for health care (Propuesta de un programa para la atención médica integral, 1996). According to key informants, cultural and religious barriers hindered local legislators from discussing the Program.

As stated by the health professionals interviewed, as a result of the lack of specific regulations regarding reproductive health, there is no unified criterion for adolescents health care (each service outlines its actions according to the team's characteristics and conceptions) and no resources specifically allocated to this issue.

1.3. The National Plan for the Integral Health of the Adolescent

Given the situation regarding adolescent reproductive health programs in Buenos Aires, we selected the National Plan for the Integral Health of the Adolescent for analysis. As previously mentioned, the National Plan was created by the Health Secretariat of the Ministry of Health and Social Welfare, thus it has national jurisdiction. It is aimed at male and female adolescents. The National Plan's general goal is "to promote and protect adolescent health through an increasing coverage in quantity and quality of services" (MSAS, 1993). Specific goals include, among others: to acknowledge adolescence as a specific stage in the individual's life, with its own needs and rights; to provide services that are adequate to adolescent needs and that have an interdisciplinary holistic perspective and to mobilize all available resources and potentialities in order to achieve good health for adolescents through preventing risk and damage.

The National Plan adopts a holistic, bio-psycho-social conception both of adolescence and of health care. Also, it states both the importance of trans-discipline participation and of the use of all available resources (media, relationships between government and NGOs, etc.) in order to achieve the global purpose (MSAS, 1995).

Interviews with two professionals involved in the National Plan's formulation indicated that they did not consider it was necessary to elaborate a national "reproductive health" plan for adolescents since that could be done by each province (coordinator of the Obstetric Area of the Adolescent Service at the University Hospital Gral. San Martín, physician, female and, Chair, Public Health Department, National University of Tucuman,

[8] Integral health includes taking a holistic and comprehensive view of health and places the patient in a social rather than just a medical context. Throughout this report, integral and holistic are used

physician, female). Nevertheless, the National Plan does have a section devoted to reproductive health that states the need to promote responsible sexuality and procreation and acknowledges that this is "a especially neglected aspect of adolescents health care".

1.4. The National Plan and its relationship with the Cairo and Beijing Platforms

It is important to note that the 1993 National Plan was approved prior to the International conferences.

According to an interviewed doctor who participated in the National Plan's formulation,

"We didn't have in mind the principles later shaped in Cairo and Beijing, but still the gender perspective was present. Being women, we knew quite well both the difficulties and discrimination suffered by women and the lack of rights". (Coordinator of the Obstetric Area in the Adolescent Service at the University Hospital Gral Jose de San Martín, female).

In fact, the National Plan includes many of the specifications which appeared in the Cairo and Beijing Platforms of Action. It states that adolescents should have access to information for a "responsible management of their sexuality" and acknowledges the importance of offering services that are adequate to the needs of adolescents and have an interdisciplinary approach. Even though not in a language of rights, privacy is mentioned as a key feature of the health care to be provided to adolescents and so is the time devoted to patient examination ("enough time to alowed adolescents to express their doubts"). Finally, the National Plan also promotes the participation of different governmental agencies, NGOs (including universities and scientific societies) and communities in the design and evaluation of interventions (MSAS, 1993). Similarities between the National Plan and the Platforms seem to indicate that: a) agreements at an international level reflected ongoing debates in different countries and that b) due to many years of professional practice, debates and exchanges, those who formulated the National Plan held the general guidelines which eventually turned into platforms.

Nevertheless, there are some differences between the National Plan and the Platforms of Action that are worth mentioning. One is the fact that there is no mention in the National Plan to the need of promoting gender equality. There is only a vague reference to "tend towards the equality of opportunity of adolescents, taking equity into account" (MSAS, 1993). In addition, there is no mention to the need of promoting male responsibility regarding sexuality and contraception. Another clear difference is that the National Plan

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interchangably.

does not use a “language of rights” except for a single mention to adolescents “needs and rights”. Furthermore, when needs are referred to it is in a rather patronizing way: “adolescents need that adults (parents, teachers, health professionals) understand and accept their sexuality. On this bases, enough and adequate information will be provided” (MSAS, 1993). Obviously, there is also no mention of an adolescent women’s right to autonomy regarding reproductive decisions.

1.5. Holistic Health Programs Obstacles and Facilitators for the Development of Adolescent Programs

In the last few years, the existence of a strong conservative alliance between the national government and the Catholic Church regarding sexual and reproductive rights has been one of the main obstacles to the development of adolescent programs in Argentina.

This alliance is the result of a long and complex historical relationship, in which, with only brief intervals, the Catholic Church strongly influenced political decisions regarding education and the family, thus interfering with the development of family planning activities and, lately, with the implementation of HIV/AIDS prevention campaigns.

In March 1994, President Carlos Menem attended the IV Meeting of Heads of State of Ibero-América held in Cartagena de Indias, Colombia, where he first stated his alignment with the Vatican’s position of defending the right to life from conception. From that moment onwards, the government and the ecclesiastic hierarchy consented to a proposal aligned with the Vatican’s policies as Argentina's official position presented at the Cairo International Conference on Population and Development in 1994, the Copenhagen Social Development Conference in 1995, and the Fourth World Conference on Women in Beijing in 1995 (Gutiérrez, 1998). Both in Cairo and Beijing the official Argentine delegation supported conservative positions and restrictions regarding abortion, reproductive rights and “different family types” while insisting on the right to life from conception (Lubertino, 1996).

These agreements, which still persist, explain the national government’s refusal to formulate laws, programs and public policies regarding health and sexual and reproductive rights. The problem is particularly serious in the case of adolescents since they are considered “minors” and thus, legally, are only entitled to receive contraceptive services with parental permission. The provision of contraceptives to adolescents was one of the contentious issues that resulted in the Senate not even discussing the Law Project on Reproductive Health that had been approved by the Chamber of Deputies in 1995. Thus,

political and cultural obstacles result in the lack of policies and, thus, of financial resources to fulfil the demand for adolescent services.

However, by acknowledging adolescent reproductive health as an issue, the National Plan to some extent legitimized the work that health teams had already been developing and implementing, in some cases for many years (in some public hospitals of Buenos Aires, for example, adolescent services date back to beginning of the 1980's). The problem, as will be shown later, is that not having an explicit policy results in the lack of institutional commitment and resources (personnel, supplies, training) and thus, services have to rely on personal commitments and informal networks. The bulk of the responsibility for serving adolescents thus falls on health professionals, as this testimony shows:

> *"I am convinced that if the church found out that I am providing adolescents with intra uterine devices, they would turn me into a newspaper headline... The central government is against contraception and always votes against family planning at an international level, while the city's government allows more room for things to happen..." (Female, physician, 38 years old, Argerich Hospital).*

1.6. Justification of Service Site Selection

Given that there is no formal program for adolescent reproductive health at the city level, we faced difficulty choosing sites to study. After a preliminary review of data from the majority of the hospital-based services which provide reproductive health care to adolescents, and informal conversations with key informants, two sites were selected on the basis of some common features and also of some differences that seemed interesting for comparison.

The Argerich Hospital has an Integral Service for Adolescents' Health care, with gynecology and sexuality as one of its specializations, while the Rivadavia Hospital has an Adolescents Service inside the General Gynecology Service. In both cases their professional accomplishment is well recognized inside and outside the medical field. Because they belong to the University of Buenos Aires Medical School, they are in charge of training professionals in the field of adolescent health care. Both services have some research experience. Both sites have also served adolescents for almost 20 years[9], which allows them to evaluate their performance over the years and identify both their achievements and difficulties. They both share a conception of integral health and an understanding of bio-psycho-social aspects, therefore responding to the spirit of the analyzed National Plan.

The Argerich Hospital provides services to boys and girls, while the Rivadavia Hospital only serves girls.

The Argerich Hospital is located in a low and middle-low class area on the city's border. It attracts a low resources population, not only from the neighbourhood but also from south suburban Buenos Aires. The Rivadavia Hospital is located in the heart of Barrio Norte, a middle class area, and is attended by a suburban population and by household help who live in the neighborhood. Because of their prestige, both hospitals also receive referrals from other hospitals.

[9] The Adolescents Service at the Rivadavia Hospital was established in 1976. At the Argerich Hospital the Adolescents Service was initially established in 1978 in one of its community health care centers and was later moved to the hospital facilities in 1983.

Chapter 2. Characteristics of the Services

2.1. The Argerich Hospital

The Argerich Hospital belongs to the City of Buenos Aires. A university hospital with comprehensive services, it serves as a training and education center for medical students from Buenos Aires University.

It is located in the south east area of the City of Buenos Aires, in a the neighborhood of La Boca. The facility provides health care to people from La Boca, San Telmo, Barracas and South suburban Buenos Aires.[10]

2.1.1. The Adolescents Service

The Adolescents Service is located in the ground floor of the building. It is clearly marked and accessible. Years ago the Service's space was limited (80 square meters with three consulting rooms connected by a hallway used only by staff members, and a waiting room). In 1991 a donation by the Bagley Foundation –a biscuit manufacturer- allowed for expansion and renovation of the facilities in order to meet the increasing demand for adolescent services. Currently the Service has five consulting rooms, a nurses' and volunteers' station, a meeting room for the medical staff, and a library.

The Adolescents Service staff includes seven pediatricians (two males and five females), one of whom is the Head of the Service (male); three gynecologists (all female); one general practitioner (male), a nurse (female) and a volunteer (female) who performs administrative tasks.

In addition there is a group of psychologists from the Psychopathology Services who care for adolescents; a social worker from the Social Welfare Service who works on detection and follow up of high-risk adolescents; an obstetrician from the Obstetrics Services solely devoted to teen pregnancies; and a pediatrician from the Pediatrics Service who provides healthcare for children of teenage mothers.

2.1.2. Assistance Dynamic

The basis for service is a holistic conception of adolescent health. The clinic-pediatricians, according to the people interviewed, are the most adequate to follow the development process from childhood to adulthood. A network of personal relationships

[10] This traditional neighborhood in Buenos Aires, originally inhabited by foreign migrants, has been always tied to two crucial events: the port´s activity and the settling of "conventillos" as the housing system; and Boca Junior´s Soccer Stadium, which confers a strong identity to the neighborhood. Most of the neighborhood population attends the Argerich Hospital.

with professionals from other services who share the staff's ideology allows broader services for the adolescents, particularly obstetrics, lab and psychopathology.

The integral attention to adolescent health implies a bio-psycho-social framework in which the relationships with the community as a reference system are crucial, as stated by the philosophical guidelines of the National Plan.

Consulting with specialists and taking a multi-disciplinary approach contribute to the existence of an actual holistic conception in health care and prevention policies. Consulting with specialists is done on an informal basis.

Inter-disciplinary care, on the other hand, has came a long way: a general practitioner is in constant touch with staff in gynecology, clinic, nutrition, psychology, obstetrics, and social work.

This inter-disciplinary approach has been difficult. First because it requires individuals from different professions (physicians, anthropologists, psychologists, sociologists, among others) appointed by the City Government exclusively for the Adolescents Service. Second, an inter-disciplinary approach requires an exchange which transcends assistance, with meetings in which diagnose and therapeutic procedures are discussed.

Inter-disciplinary activities were successfully carried out for a three year period, between 1992 and 1994, with support from the Kellogg Foundation, which allowed the development of a work plan articulating the Service's goal in the context of the community's characteristics. Once the financial support ended, the community activities concluded except for the work of some physicians who still carry out some of the work plan activities on a volunteer basis.

The Service follows the hospital's general rules. Patients are admitted in a centralized way through a computer system. First they are given an appointment and then go to the Service for health care. Once told when to return, they fix a new appointment at Outpatient Services.

The procedure results in a series of obstacles hard to solve for the Adolescents Service staff, because patients are forced to wait long hours for health care; some end up leaving before they receive care.

The staff tries to demand preferential attention for their patients when assigning turns, because

"the adolescent who is driven away twice at the Admitting Area doesn't come back again. Over the years some professionals came to understand this and now examine patients even if they

don't have an appointment... They understand that the demand of adolescents must be considered as an urgency because of their vulnerability (Female, physician, 38 years old, Argerich Hospital).

The Service is open from 8 a.m. to 5 p.m. Professionals are divided into two shifts with equal amount of hours in each shift[11]. The workload in each shift, however, is unequal because most patients tend to come during the morning shift.

Table 1: Consultation: volume and flow[12]

Year	Morning	Evening	Total
1994	7.458	5.400	12.858
1998	10.666	5.372	16.038

When receiving a patient at the Service, the doctor in charge starts his or her clinical record by inquiring about various subjects: personal information, development/growth record, prior illnesses, school level, family members, addictions, etc. A medical student at the Service stated:

"When I receive a patient I go straight into clinical matters, but then a doctor comes and starts asking more and deeper questions... I forget to ask about other things... I don't carry it inside... Only now I've learnt it" (Medical student, 24 years old, Argerich Hospital).

When the Adolescents Staff asks for a crossed examination by a psychologist, the patient is given an appointment for admission. If there is an emergency, the patient is seen right away. All patients agree to their turns, and therefore waiting periods never exceed a ten minute lapse. Very few adolescents seek psychological attention spontaneously. Those who receive such attention are mostly referred by other professionals in the hospital.

Difficulties arise with analysis and lab studies. Even if all complementary examinations are done in an organized, efficient and fast way, the delivery of results is slow, therefore delaying diagnosis.

Medicines are obtained through private laboratories. Oral contraceptives and condoms are provided both by private labs and the Buenos Aires City Responsible

[11] Traditionally, Argentina´s hospitals are open during morning hours. Hospitals managed by Buenos Aires City Government now include day-long attention. However, because patients are not aware of this possibility, most of them attend the hospital in the morning, therefore overloading professionals in that shift.

[12] Data extracted from *Buenos Aires Adolescents Project,* prepared by the Adolescents Service at the Argerich Hospital and edited by FUSA 2000, Buenos Aires (1995).

Procreation Program, which also provides intra uterine devices (IUD) upon request from the Service.

The Hospital charges a fee for each service. A visit costs $ 2, equivalent to US$ 2. If the patient is unable to pay, he/she can ask for a Poverty Certification, which works as an exemption. Users of the Adolescents Service do not have to pay in order to facilitate their access to health care.

2.1.3. Characteristics of the population

All requests for service by adolescents and young people ages 10-20 for whatever reason, are referred to the Adolescents Service.

There are two age groups in which types of requests are concentrated. Adolescents ages 13 to 15 are affected mostly by seasonal illnesses (colds, flu, allergies, among others) and 70% of the times visit the Service accompanied by an adult who is in charge. Young people ages 17 to 20 tend to visit the Service for sexuality related care. Ninety percent come on their own or accompanied by peers; 60% of them are women and 40% are men.

According to references, the reason could be:

"I believe it has a lot to do with care... particularly in the case of contraceptives... I believe women consult more than men at all ages" (female, physician, 38 years old, Argerih Hospital).

"As regards men, professionals state that "they are afraid of coming to the Service... They are not used to, they are shy and find it pretty difficult to ask, that's why they come through emergency" (Male, physician, 45 years old, Hospital Rivadavia).

Patients generally come from two socio-economic levels: low middle class and lower class. Many patients have unmet basic human needs, although there are no cases of extreme poverty. Most patients have completed primary school but dropped out of high school, or attend it with difficulties.

In most of the interviews, professionals refer to changes that have occurred in the assisted population in terms of both their socio-economic and educational level:

"Ten years ago, when I started coming to the Hospital, I saw poor people; I was surprised to see girls come in their muddy feet carrying two or three children. In the last two years, that population has stopped coming" (Female, physician, 38 years old, Argerich Hospital).

"We serve a low income population, as can be easily seen at the moment which the country is going through, but their characteristics have changed. Before, they used to be poor people from suburban areas or squatters. Now it's the new poor people, sometimes scared of coming to a public hospital, and prejudiced; however, they are receptive, continue to come, and ask for their appointed doctor" (Female, physician, 42 years old, Argerich Hospital).

Regarding the patients' families, professionals mention cases of non-functional families: parents who beat their children and/or spouses, alcoholism, all sorts of domestic violence, and a high record of abuse, which has grown even more visible in the last few years. Research developed at the Service indicates that abuse is a risk factor for early pregnancies.

2.1.4. Consultation: manifest and hidden reasons for contacting the service

Men consult basically for seasonal illnesses such as flu, aches, bronchitis, swollen throat. Many of the interviewees said that while at the service, men make requests regarding contraception, sexually transmitted diseases and sexuality in general.

The Service tries to stimulate interest by handing out leaflets and providing condoms or oral contraceptives. By expressing concern and generating trust, they expect to facilitate change in patients' attitudes towards health care. When change is not achieved, they work with the "lost opportunity" concept, and turn to the community in order to win patients over.

Boys who are attending school are sent to the Service for a general check-up, which is required for practicing sports.

Interconsultation with Psychology Service is due mostly to eating disorders, pregnancy, family problems, etc.

Gynaecologists state that girls' reasons for consultation vary according to age. Between the ages of 13 and 15 girls consult more frequently for upset or painful periods, breast disorders, etc. Between the ages of 17 and 20, girls' consultation is related to contraception, sexually transmitted diseases, condyloma, and genital diseases.

"Usually we detect infections pretty fast, because all patients with sexual activity go through a Pap smear and a colposcopy" (Female, physician, 66 years old, Argerich Hospital).

2.1.5. Community oriented activities

The Adolescence Service of the Argerich Hospital participated for three (1992-1994) years in the above mentioned Kellogg Foundation project regarding health care, research and extension trans-disciplinary experience for the community.[13]

[13] "The experience was developed between 1992 and 1994 with financial help from the Kellogg Foundation and support from the Buenos Aires City Health Secretariat (which provided infrastructure and guarantees), the Pan-American Health Organization, the "Pedro Mosotegui" and "Rocca" Foundations, the Bagó Laboratories, and the FUSA 2000. As a result of the experience, a book on the Buenos Aires Adolescence Project was published.

The project aimed at “contributing to the improvement of the biological, psychological and social developmental conditions of adolescents, their families and the groups they belong to.” Specific objectives were to: “redefine and strengthen control and care of adolescents attending the Hospital’s Adolescence Service, be it spontaneous demand, promoted attendance or referral,” “develop a system for extra-hospital health care in influence areas,” “design an integral teaching system for the Health Team appointed to the project both inside and outside the Hospital” (Servicio de Adolescencia del Departamento Materno Infanto Juvenil del Hospital Argerich, 1995).

As perceived by providers, it was a nurturing experience: the interrelationship among 25 professionals from different fields of medicine and social services resulted in collective evolution, and helped to improve the quality of care and the services' ability to attract patients who do not spontaneously contact health care services .

We detected nostalgia for this work environment among the few remaining paid and volunteer providers who try to recreate the experience despite economic and bureaucratic obstacles.

During the project period, outreach was done at schools, foster homes and prostitute shelters. Even though the project has finished, providers have managed to keep two daily time slots for homeless children.

A professional said:

“We are not currently reaching the community because of the actual public health conception: extended working hours, bureaucratic procedures required for external attention, concurrent students’ work not allowed[14], etc. Anyhow, we are trying to resume external teams, while the community comes here” (Male, physician, 48 years old, Argerich Hospital).

Also, some members of the Adolescents Service are trying to recreate an Information Service devoted to each aspect of integral health in the waiting area, where patients spend a considerable amount of time while waiting for health care. Professionals refer to the importance of this Information Service, which is usually coordinated by medical students, who are closer to adolescents in age, and therefore with better chances for bonding.

[14] Postgraduate education in medicine can take two forms: recent graduates can do a residency or what is called a "concurrencia". In the first case the trainee becomes part of the medical staff, after a highly competitive entrance exam, and receives a salary. There are far more applicants for residencies than residencies available. "Concurrentes" are medical school graduates attend the hospital for training without receiving a salary. Lately "concurrentes" have been prohibited from practicing medicine at the hospitals and they can just observe what the residents and other medical staff do.

The activities undertaken during the project could only be done with sufficient human and economic resources and the hospital's commitment to guaranteeing and sharing the project. At the moment it is difficult to continue the broad range of activities due to lack of economic and human resources, and due to hospital rules which obstruct the possibility of performing outreach activities to attract adolescents who generally do not come to the hospital. At the hospital, efficiency is measured through productivity (daily number of patients attended), which prevents providers from spending time in prevention activities among adolescents who represent a highly vulnerable population.

2.2. The Rivadavia Hospital

The Rivadavia Hospital belongs to the Buenos Aires City Government. It is a comprehensive university hospital providing health care in all specialities. It serves as a training and education center for medical students at the Buenos Aires University. The Hospital is located in the north area of Buenos Aires City, in the Barrio Norte neighborhood, characterized by a middle class and high middle class population. The Hospital is located in a spacious property with various buildings for the different Services and ample green spaces between them.

It differs with the Argerich Hospital in that it does not operate as the area's primary assistance center. Its patients are Argentine and foreign migrant women who work as maids with residence at their employees' houses, women from suburban Buenos Aires, and referrals from other health care centers.

The Adolescents Consulting Room, in which part of this research was conducted, is located in the General Gynecology Services.

2.2.1. The Service

The Gynecology Service is 100 meters away from the main entrance door. The Adolescents Consulting Room waiting area is on the ground floor close to the Service's entrance, there are also two admission rooms, two rooms for gynecological attention, and a meeting room for doctors and psychologists. The rooms are warm, comfortable and fully equipped. The Psychology Area is located on the fourth floor where there is an office where the sexual information groups gather, equipped with a computer, a TV set and a VCR. The Adolescents Service staff is composed by five gynecologist (4 females, one male), one of whom is the Head of the Service (female); five female psychologists; two

education specialists who come in once a week, and a social worker who is available twice a week.

2.2.2. Assistance dynamics

Service to adolescents at the Rivadavia Hospital is also based on the concept of the holistic health of adolescents. In principle they agree with the holistic philosophy proposed by the National Adolescent Integral Health Plan, even if they only assist women in some of the areas involved in holistic health. Since its origins in 1978, the team serving adolescents has consisted of doctors, gynaecologists, psychologists, sociologists and educators, all in constant contact with social workers. The team has also established a network of personal relationships with professionals from other Services who share their concept of inter-disciplinary consultation (obstetrics, lab, and endocrinology, which used to have a doctor appointed to the Adolescence Service). An interdisciplinary approach has been a very important goal throughout the service's history: all professionals in adolescents' health care share the same space and participate in joint sessions.

Assistance to adolescents is provided on Tuesdays to Fridays from 8 a.m. to noon. Mondays are devoted to meetings, teaching and research. At the Mondays meetings the whole team works on a case generally presented by the psychologists, and decides which strategy and therapy to follow according to its bio-psycho-social perspective. Doctors also have a specific meeting in which they share information about patients and progress on scientific research under way. The Psychology Team has two meetings: one for literature updates, and another one with an external supervisor to discuss the most complicated cases, both for education and therapeutic purposes.

Patients access the Hospital through the Outpatients Gynecology Consulting Room for Infants and Youngsters where they are admitted upon completion of their clinical history, and receive health care for their explicit request. According to the diagnosis they are then referred to the Consulting Room for Adolescents at the Gynecology Service[15]. They are given turns and therefore do not have to wait for too long.

Admission to the Adolescents Service is done both by a doctor and a psychologist, and whenever possible an extensive social inquiry is conducted. The clinical history includes personal information, general medical and reproductive history, socio-economic

[15] The Adolescents Service at the Rivadavia Hospital is not an independent service itself since it belongs to the General Gynecology Service where it is identified as the Adolescents Consulting Room. For simplicity purposes we refer to it as Adolescents Service.

data, religion, reasons of consultation, family members and illnesses records, and addictions among other information.

After admission every patient is asked to attend a sexual information meeting coordinated by education graduates.

Psychological care involves different stages. First, all patients are admitted jointly by a psychologist and a doctor who determine the problem. Then, the psychologist briefly explains to the patient how they will work and the importance of participating both in the information groups and the diagnose interviews. Day, time and frequency of attendance are agreed with the patient. Either group or individual therapy is chosen in each case depending on the diagnosis.

Lately, the increase in the number of patients who do not return for follow-up has indicated the need to develop activities in the waiting room to provide information on team work and the importance of receiving attention from a doctor, a psychologist, an educator, and a social worker among other staff.

One of the most important obstacles described in the interviews with doctors is the difficulty of making an accurate medical diagnosis, on one side because of the lab's delays (doctors say that they only receive things on time if they request them in person), and on the other hand because of the cost of some complex tests which patients cannot afford.

Supplies are provided by private laboratories, be it medicines, oral contraceptives or condoms.

As all the public hospital, the Rivadavia Hospital charges a fee which varies according to the services. A visit costs $ 2, equivalent to U$S 2. If the patient is unable to pay, he/she can ask for a Poverty Certification, which works as an exemption. Patients at the Adolescence Service are not required to pay the fee.

2.2.3. Characteristics of the population

Adolescents and young people ages 10 to 21 come to the Adolescents Service with most patients between 17 and 20. Some girls younger than 10 also come to the hospital.

Two socioeconomic groups generally come to the hospital: lower and middle class groups. The first group consists of maids, Argentine and neighboring countries immigrants, employees at stores and supermarkets, unemployed women, and girls living

at foster homes among others. The education level of patients corresponds to complete or incomplete primary school.

According to a person interviewed,

"...the lower class has so many problems that they don't even come to the hospital any longer... I guess they receive attention at neighborhood wards... there is no preventive function left" (Male, physician, 45 years old, Rivadavia, Hospital).

The Adolescent Service also treats middle class patients whose parents have lost their jobs and have no medical insurance due to the economic crisis, many of them are high school and university students.

Eighty-one percent of the patients are single, 13.7% are unmarried but living with their mates, 4.9% are married, and 0.1% are divorced.

Figures from 1998 showed that 81.9% of the hospitals' patients were from Argentina, 8.06% from Paraguay, 6.98% from Perú, and the rest from other neighboring countries. Changes in the population have occurred in the last four or five years. Patients now are more likely to suffer from lack of family companionship and lack of economic resources among other problems.

"You have to respond to the manifest reason for consultation, but then again, the rest (social and family matters) is so complicated, so broken, so painful, that you have to try to organise it into a whole in order to be able to provide health care. Before, social networks were much more articulate". (Female, psychologist, 44 años, Rivadavia Hospital).

2.2.4. Consultation: manifest and hidden reasons for contacting the service

Reasons for contacting the Adolescents Service according to age in 1998 were:

- For girls ages 11 to 15: upset cycles (28.9%), vaginitis (24.6%), check ups (11.5%), contraception (8.6%), breast disorders (5.6%), pregnancy (4.3%), sexual abuse (2.8%), psychology (2.8%), and others (Servicio de Ginecología, Sección Adolescencia, Hospital Rivadavia, 1998).

- For young women ages 16 to 20: contraception, (23.3%) upset menstrual cycles, (16.1%) 11.9% gynaecological check ups, vaginitis, (11.3%) pregnancy, (6.2%) pelvic pain, (5.6%) amenorrhea, (5.0%) breast disorders, (3.2%) sexual abuse (0.5%), incomplete abortion (0.3%), and others. In the last three years, among young women ages 16 to 20, contraception has become the first reason for consultation, leaving pregnancy in the 5th place.

In the interviews, psychologists indicated a number of latent motives for coming to the Adolescents Service including: body care, contraception, and conflicts related to future life goals among other reasons.

All persons interviewed referred to the importance of prevention, follow-ups and team work when dealing with contraception and sexuality among adolescents and young people.

Table 2: Consultation: volume and flow

	1995	1998
Gynecology	3,757	2,756
Psychology	1,791	1,081
Social Work	878	177
Information Groups		60
TOTAL	6,426	4,074

The decrease in the number of consultants between 1995 and 1998 is worrying. It could be related to economic difficulties and changes in the social status of patients.

In 1998, the Psychology Service admitted 241 patients. Eighty-seven were seen jointly with doctors and 154 were strictly psychological consultations. Difficulties in follow-up were found.

Nearly 50% of patients do not return for follow-up care which might be caused by a) the socio-economic situation; b) adolescents who belong to families with difficult life situations; c) migrants who cannot find a job and therefore move on (Servicio de Ginecología, Sección Adolescente, Hospital Rivadavia, 1995 and 1998).

2.2.5. Community oriented activities

The Service does not have relevant work experience in the field of community oriented activities. However, cases which could not be treated were referred to neighboring institutions (for example drug addictions and violence among other problems).

In the recent past, some activities were developed jointly with community institutions. The Gimnasia y Esgrima Club provided 30 grants for sports practice and an art school taught lessons to patients. Also, a group of volunteers provided school support. Due to the lack of social workers at the Service, those activities have now stopped.

Chapter 3. Adolescent Sociodemographic and Epidemiological Profile

3.1. Sociodemographic Characteristics

According to the 1991 census, 9% of the country's population lives in the City of Buenos Aires and another 25% in the 19 Greater Buenos Aires districts. The city's population (3,036,891 inhabitants in 1997) has completed the demographic transition and thus presents a relatively aged structure (see Graph 1 in Annex 1). Indicators of this situation are: the low proportion of children and adolescents (18.2% of the population under 15), the high percentage of the elderly (17% is 65 years old or more) and the average age of the population: 38.8 years for both sexes (Gobierno de la Ciudad de Buenos Aires, Publication No. 32, 1998).

Adolescents (aged 10 to 19) account for 13.8% of the city's population (the 10-14 group representing 6.3% and the 15-19 group 7.5%). The male/female ratio is 101.79 males for every 100 females in the 10-14 group and 100.60 males for every 100 females in the 15-19 group.

Ninety-seven percent of males and females aged 10-14 and three-quarters of those in the 15-19 group were attending school in 1991[16]. Two situations can be identified among those not attending school: some have dropped out and others have left the system after obtaining at least one credential. In the 10-14 group, the percentage is low and very similar: 1.4% drop out and 1.1% graduate. Those never attending school total 0.4%. The dropout rate increases in the 15-19 group: 11.5% for males and 9.6% for females. Another 13% of both sexes were not attending school at the time but had completed either the primary or secondary school level. The percentage that never attended school is 0.3% (see Table 2 in Annex 1).

Regarding socio-economic conditions, special tabulations of the 1997 Permanent Household Survey indicate that some 14.3% of adolescents (10-19) in the City of Buenos Aires live in households "below the poverty line" and another 5% in households with Unmet Basic Needs[17]. By way of comparison, it should be noted that in 1991 the proportion of households with unmet basic needs was: 16.5% for the country, 7% for the City of Buenos Aires and 16.5% for Greater Buenos Aires (INDEC 1997, p. 85).

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[16] In Argentina, federal law No. 24.195 (April 1993) stipulates mandatory school attendance between the ages of 5 and 15. In the province of Buenos Aires, and thus in the 19 Greater Buenos Aires districts, a provincial law extends the period of mandatory education up to 17 (the conclusion of the "polimodal" model).

[17] The Unmet Basic Needs Index is used by the National Institute of Statistics and Census. It combines indicators such as crowding within the household, characteristics of the house, schooling of the head of the household, and number of children that do not attend school.

Also, according to the Permanent Household Survey, 26% of those aged 15-19 are reported to be economically active in the metropolitan area[18]. When data are disaggregated by sex, clear differences emerge: 32.5% percent of males and 19% of women hold jobs or are looking for one. The percentage of the unemployed is similar: 9.5% for males and 9.7% for females (see Table 3 in Annex 1). Half of the employed adolescents work in Commerce, approximately 15% in Industry and 15% in Services. The average wage of workers in this age group is US$ 287 (approximately one and a half times the minimum salary), with small variations between sectors and industry registering the highest levels.

Regarding marital status, 95.7% of women and 98.7% of men aged 15-19 were single (1991 data). Four percent of the women in this age group declare themselves to be married or in consensual unions. It is worth mentioning that the nuptiality rate of women aged 15-19 has been declining steadily: from 17.3 per 1000 in 1980 to 4.0 per 1000 in 1997. The rate for men under 20 has also dropped by one third: from 3.8 per 1000 in 1980 to 0.9 per 1000 in 1997 (Gobierno de la Ciudad de Buenos Aires, 1998).

3.2. Mortality

The general mortality rate for Buenos Aires has been stable during the period 1970-97. In 1997 the rate was 11.0 per thousand. Increases in the rate figures accompany age and sex: the former relates to the obvious increase in the risk of dying with age, while the latter describes higher mortality among men (12% higher than women).

The rates for the adolescent population are no exception: 0.23 per thousand for males ages 10 to 14 and 0.19 for females in the same age group. Adolescents from 15 to 19 years old show mortality rates of 0.63 per thousand among men and 0.29 among women. External causes of mortality and morbidity (Chapter XX of ICD 10) account as the first cause independent of age and sex differences. Even so, the magnitude of external causes is higher among men: 45% for those at ages 10 to 14 and 60% for those 15 to 19. Rates for women for the same age groups are 38.9% and 29.4% respectively (see Table 4 in Annex 1). Causes following in magnitude should be carefully analyzed since the number of cases is so small and interpretations based on these data can change from year to year. In this context it is reasonable to say that tumors constitute the second death cause for all groups, followed by respiratory illnesses.

[18] In Argentina, youth labor is forbidden until the age of 18. Yet, between 14 and 18, legislation

Some of the external causes deserve special comment. Suicide rates have a particular age and sex pattern: while in most age groups suicide rates for men are twice as high as women's, in the 15 to 19 years of age group women have a higher rate than men (3.5 per hundred thousand vs. 1.7) (see Table 5 in Annex 1).

Car accident related deaths follow a pattern where the difference between men and women increases with age. In the age group 40-44, men are four times more likely than women to die from car accident related deaths. In the 15-19 age group, men have a rate of 3.5 per 100,000 compared to women whose rate is only 0.9 per 100,000 (see Table 6 in Annex 1).

Finally the death rate for AIDS was 14 per 100,000 in 1997 in the city of Buenos Aires. The male population had an AIDS related mortality rate of 25.1 per 100,000 compared to the female population´s rate of 4.7. The rates among adolescents in 1997 showed similar results to previous years: in that year there was no AIDS caused death among women of ages 15 to 19, and only one among men of that same age group (see Table 7 in Annex 1).

3.3. Morbidity

The available adolescent morbidity data is based on the discharge diagnostics at public hospitals of the city of Buenos Aires (MSAS, 1998). The age group 10 to 14 represents 3.4% of the total of discharges while those 15 to 19 account for 6.7% of that total.

The number of discharges of women and men 10 to 14 show almost no difference in absolute numbers. The cause structure for this age group indicates that traumatisms and poisoning[19] are the predominant causes among men (19.9%), followed by digestive diseases (12.6%) and congenital abnormalities (11.5%). For women in this age group traumatisms and poisoning are the first discharge causes, which along with digestive diseases each account for 11.2% of the discharges. These two groups of causes are followed in their magnitude by obstetric causes and nervous system and senses organs illnesses that each account for 8.8% of discharge diagnosis (see Table 8 in Annex 1).

Among women ages 15 to 19, normal delivery and complications related to pregnancy, partum and puerperium, account for 45.2% and 21.7% respectively of discharge diagnosis. This indicates that reproductive events are accountable for about

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allows the youth to work provided they count with prior parental authorization.

three times as many discharges as the other causes (6090 vs. 2329). Considering only obstetric causes related to morbidity, leaving out normal partum, direct obstetric causes (toxemia, hemorrhage, sepsis) become the most important cause (80.1%) followed by pregnancy ended in abortion (18%) (see Table 9 in Annex 1).

Among men 15 to 19, poisoning and traumatisms are the first discharge cause (20.8%), followed by digestive diseases (11.4%). Mental disorders and respiratory system illnesses appear as the third cause in equal proportion (7.9%) (see Table 10 in Annex 1).

Finally, the absolute number of traumatic causes among men is nearly the same as among women. Age makes no difference when looking at the relative weight that each subgroup of traumatic causes has for both males and females.

3.4. Adolescent Pregnancy

The adolescent fertility rate is relatively high compared to the general fertility rate. This rate increased during the 1970's (as occurred for all age groups) and reached a peak in 1980. Since then, the adolescent fertility rate has decreased to the same level as in the 1960's.

Adolescent fertility decreased from 38.71 per 1,000 in 1980 to 31.7 in 1995. This decrease explained by the decrease in the late adolescence fertility rate[20] (76.8 per 1,000 in 1980 to 60.6 in 1995) while the early adolescence fertility rate[21] remained unchanged.

However, the percent of children born to adolescent mothers has increased from 11.2% in 1958 to 15.7% in 1995. In the city of Buenos Aires 16% of the total of births are to adolescent mothers, a proportion that is coincident with the national mean. However, there are great regional contrasts in the adolescent fertility rate: in 1995 the early adolescent fertility rate was 0.7 per 1,000 for Buenos Aires and 4.6 for Chaco. The late adolescent rate was 2.5 per 1,000 in Buenos Aires and 102 per 1,000 in Formosa. The lower rates for Buenos Aires can be attributed to the fact that -according to a study with a representative samples of seven metropolitan areas of Argentina- 86.4% of adolescents ages 15 to 19 were using or had used contraceptives (INDEC, 1996).

Regarding maternal mortality [22], a study by Vinocur et al. (MSAS, 1987) found an under reporting of deaths (40% in the city of Buenos Aires). They showed that fluctuations

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[19] According to the IX International Classification of Diseases, the category “traumatisms and poisoning includes fractures, poisoning, burns and other traumatic events.

[20] The late adolescence fertility rate includes adolescents ages 15 to 19 years old.

[21] The early adolescence fertility rate includes adolescents ages 10 to 14 years old.

and decreases observed must be explained carefully before conclusions are formed. The small number of cases also makes reaching conclusions on maternal mortality difficult.

In 1980 the maternal mortality rate of Buenos Aires was 3.9 per 10,000 live births, maternal mortality descended to 1.1 in 1985, increased to 3.9 in 1990 and went back to 1 per 10,000 live births in 1995. In 1997 no maternal death was recorded in the city. Regarding the structure of causes of maternal mortality, while abortion represents one-third of maternal deaths for the country as a whole, in the city of Buenos Aires abortion complications account for at least half of the reported deaths (see Table 11 in Annex 1).

3.5. Substance Abuse

In 1999 the first National Study on Consume of Addictive Substances was conducted in Argentina[23]. According to this source, 65% of males ages 12-15 and 52% of females of that age group had consumed alcohol in the last 12 months. Regarding illicit drugs (marihuana, cocaine, inhalants, opium and anaesthetics, etc), 2.7% of males and 3.3% of females of that same age group had consumed them in the above mentioned period. Among the population ages 16-24, 91% of males and 82% of women had consumed alcohol in the last 12 months. Tobacco consumption was lower: 57% of males and 47% of women reported having consumed it. Regarding illegal drugs, 12% of males and 6% of women had consumed marihuana and 7% of males and 3% of women had consumed cocaine.

[22] In 1995 in Argentina the maternal mortality rate was 4.4 deaths per 10,000 live births. There are important regional differences: in Chaco the maternal mortality rate was 12.6 deaths per 10,000 live births and in Formosa and Jujuy, more than 10 deaths per 10,000 live births.

[23] Secretaría de Programación para la Prevención de la Drogadicción y la Lucha contra el Narcotráfico. (Planning Secretariat for Prevention of Drug Addiction and Fight Against Drugs). Buenos Aires, Argentina. 1999.

Chapter 4. Adolescent health from the providers' perspective

4.1. Providers' perspectives on integral health, reproductive health, reproductive rights and gender

In the selected services, 15 interviews were conducted with medical doctors, psychologists, coordinators of the medicine and psychology areas, and a medical student.

Both services share a notion of holistic health for adolescents and describe their approach as a bio/psycho/social one. This means that symptoms are regarded as indicators of "problems" at any of these three levels. The idea is not just to "cure pains" but to take into account all the aspects of the adolescent's life. In the words of one of the doctors interviewed:

"....if you don't want to find out, you treat the symptom, and that's it...you don't find out about anything. Then, there are no abuses, no addicts, no psychological problems, you don't even find out how the family is conformed and when you get into it....you have no other choice but to give information, to provide material, to invite the patient's family and partner to come, to find out about the risks and inform them to the patient, to see what the patient's environment is like, etc. That is the criteria of the service" (Female, physician, 38 years old, Argerich Hospital).

Developing and implementing this perspective has meant, for many of the professionals, a considerable shift from the perspective in which they were trained at medical schools:

'"we have an etiological concept of health, we see it as individual nosological entities, lets say, diseases to be cured. From this starting point we had to develop a different conception: integral, with emphasis on prevention in all matters related to reproductive health" (Male, physician, 45 years old, Rivadavia Hospital).

This "philosophy" is not easy to implement for several reasons. One of them is the existing tension between the number of patients doctors have to see in their working hours and the fact that getting to know the adolescent's family and environment and detecting underlying demands is a time consuming process. Other factors that hinder the implementation of this perspective are, sometimes, the attitudes or expectations of the population. As one interviewee explained:

"..when an adolescent comes to the consulting room and you tell him "I'm going to examine you", he immediately asks, "but why if I only have a cold? Why do I have to get undressed if I only have a sore throat? This shows that approaching their body in a global manner is a very difficult process" (Male, physician, 33 years old, Argerich Hospital).

In both services, the notion of holistic care is to some extent reflected in the clinical history form, where besides the manifest reason for consulting, the patient is also asked questions about family conditions and school attendance, among others. Professionals interviewed indicate that these questions are useful triggers of other aspects that may be causing anguish but are not openly mentioned, such as sexual matters or violence.

The idea of holistic health care also means that the patient will visit different professionals. As one of the psychologists interviewed said,

"...we tell the patient why we work as a team. We believe that even though they come to us because of something specific, other things are certainly happening to them, and that one professional alone cannot solve all the different problems they are facing in this difficult and constantly changing stage of life" (Female, psychologist, 44 years old, Rivadavia Hospital).

Regarding health providers perspectives on reproductive health, the majority of them share the idea that sexuality is related to love, pleasure, self-care and responsibility. They are concerned with adolescents preventing both unwanted pregnancies and STDs/HIV-AIDS and believe information plays an important role in this process.

A series of statements were used as triggers to explore providers´ perspectives on gender and on sexual and reproductive rights (see Interview guide in General Annex). Generally, the results of the interviews showed that providers agree with adolescents´ right to privacy, and to receive information and services on reproductive health matters without needing to be given permission by or accompanied by their parents. Doctors argue that even though legally they would need parental consent for any medical practice, they only notify parents when a high risk situation is detected. Professional confidentiality is the principle they use to explain this criteria. Otherwise adolescent access to reproductive health services would be severely jeopardized.

When asked if they agreed that boys were more inclined to high-risk behaviors than girls, most interviewees did not agree. Only one pointed out:

"There are certain behaviors that are more common in boys, such as drugs, accidents, violence, and then there are others to which girls are more exposed, and these are obviously those of reproductive health" (Male, physician, 33 years old, Argerich Hospital).

As regards girls' higher risk of contracting HIV/AIDS due to their lower capability to negotiate condom use, 10 out of 15 interviewees acknowledged the differential position of boys and girls regarding the adoption of safer sex practices. For instance, one interviewee

mentioned that

"Well yes, the boy is the one who wears it. The girl can tell him to wear it, try to convince him. Generally, it is girls who bring up the subject that `No, my partner does not want to wear it´" (Female, psychologist, 56 years old, Rivadavia Hospital).

In only one case there was an explicit reference to "women's subordinated position in society." Others emphasized class rather than gender as a "risk factor". Finally, some answers described the effects of the sex/gender system on girls´ attitudes and abilities without explicitly recognizing it One of the respondents noted:

"I don't know if girls have a weaker ability to decide, but sometimes for them caring about themselves is not so important. I don't know whether this has to do or not with their ability to decide, but they say things such as `He didn't want to wear a condom, but I had sex with him anyway" (Female, psychologist, 44 years old, Rivadavia Hospital, our emphasis).

Regarding health services responsibility in the promotion of users' self-respect and autonomous behaviour, 12 interviewees said that, to some extent, this was part of their task.

"It is the health services' responsibility, as far as they can do it. That is to say, there are limitations, because during a short interview you can not change an individual but at least you can make him see and talk about the problem. Then, they would have to see how to modify the situation, but it is the responsibility of the health services to at least make them see the problem" (male, physician, 33 years old, Argerich Hospital).

"It is not our responsibility only. A health service might help, I mean, to promote it, but is not our only nor our final responsibility" (female. psychologist, 34 years old, Rivadavia Hospital).

"It is the responsibility of the health services as much as it is the responsibility of every responsible adult human being. The fact that adults do not take responsibility for it does not mean they are not responsible" (Female, physician, 38 years old, Argerich Hospital).

Even the only person who explicitly disagreed with the idea that health services have the responsibility to promote users' self-respect, recognized that services do in fact play this role

"It is not their responsibility, but as a matter of fact, they promote it. Since these girls are being taken care of, they have a place to go for help, then they recover their self-respect. Just caring for them, giving them a group, making them feel they belong somewhere, is promoting..." (Female, psychologist, 56 years old, Rivadavia Hospital).

The statement "fertility regulation is the right of every individual" received general consensus. Some interviewees immediately associated "right" with "responsibility": As one of them said,

"Yes. it is ultimately their decision. What I try to do in general, is make them become responsible for the situation, make them see that, when they go to bed with a boy they have to be responsible for what this means" (Female, physician, Rivadavia Hospital).

As regards whether women have the right to use birth control methods even if their partners disagree, 11 interviewees where in favor of women's autonomous decision, 2 disagreed and another 2 did not know how to answer. Nevertheless, the expectation is that decisions are taken jointly

"I see cases in which the couple does not agree, but the girl can use them anyway if she wants to. I think it would be better if she talked with her partner and they both agreed. The idea is for them to think as a couple, not for one of them to decide" (Female, psychologist, 34 years old, Rivadavia Hospital).

Some of the respondents gave the impression that, according to providers, women/girls would be more or less entitled to an autonomous decision regarding contraception depending on the type of relationship they have.

"The girl has the right. Then, how to solve the problem within the couple, when one wants to use a birth control method and the other does not, is something that they will have to find out. The girl has the right because the body is hers, and so is the decision. First we have to make clear what we mean by couple, if it is something circumstantial, like "we have sex every once in a while", or if it is couple who that been together for many years. Then it is different, it is something they will have to talk about, but the girl obviously has the right to decide" (Female, psychologist, 44 years old, Rivadavia Hospital).

Finally, when asked whether interrupting a pregnancy is ultimately a woman' decision, most providers´ answers were affirmative (11 agreed, 2 disagreed and 2 chose not to answer). It is worth mentioning that this was a difficult statement for interviewees to react to regardless of their sex. Ideally, in their perspective, this is a situation to be "solved" by the couple. The reality of many of the female adolescents with whom they interact is a different one:

"What we see is that the girl almost always has to face this situation alone. This does not mean that I agree, but this is what happens" (female, physician, 38 years old, Argerich Hospital).

"I don't know so I don't answer. (Laughing and ironically) I think it is a complicated question. Generally, in the end it is the girl who decides" (Female, psychologist, 44 years old, Rivadavia Hospital).

Reasons given to accept a girl´s decision to interrupt an unwanted pregnancy are similar to the ones given in relation to the use of contraception against the will of the

partner:

"It is basically a girl's decision because she is the one who will have to "deal" with the baby, she can talk it over with her partner, but basically it is her decision" (Female, physician, 66 years old, Argerich Hospital).

4.2. Health care providers´ perspectives about reproductive health issues

4.2.1. Birth control

Regarding birth control methods, the Adolescents Services at the two hospitals have a different work methodology. At the Argerich Hospital, patients receive information about all the existing methods, and then choose, together with the health professional, the one that better fits their particular situation.

In the case of the Rivadavia Hospital, after a joint doctor/psychologist admission interview where different issues regarding their health and their personal life are discussed, patients attend an Information Group coordinated by an education specialist. These groups approach subjects such as getting to know the body, how to take care of it, and the different birth control methods available, as well as the myths and beliefs about them. Staff at the Adolescent Service at the Rivadavia Hospital believe that once the group activity finishes and the patient meets with the doctor, she is better prepared to choose a birth control method. At the Rivadavia Hospital birth control is the first cause of adolescent visits. Providers consider this a "success" since for many years the main reason of adolescence contact with the service was pregnancy. They believe this change in the demand is related to the preventive work they perform.

Services also have some different criteria regarding the IUD. At the Rivadavia Hospital, they do not give the IUD to women who have not had children, while at the Argerich Hospital, they do not consider parity to be absolutely necessary for IUD use. While they agree that nuliparous women are not the best candidates for IUD insertion, they give it to patients who will not use another method.

In both services, one recurrent subject is the great difficulty that both male and female adolescents have in becoming responsible about birth control. Among the reasons for this, providers mention: lack of information, conflicting attitudes towards sexuality that are common in this age, difficulty in obtaining birth control methods, and that the majority of girls have not been taught physical self-care during childhood.

The fact that adolescents do not frequently have steady partners was also raised by

providers as partly explaining the irregular or unreliable use of birth control methods. Unequal gender power relations was also mentioned as a factor affecting contraception. As one interviewee said

“Girls are subordinated to boys, since they ignore whether their partner is really being careful (meaning using some type of contraception) as they say. This depends largely on the particular situation of each patient" (male, physician, 45 years old, Rivadavia Hospital).

Still, the basic idea as regards birth control is that it is a matter that should be handled by both partners.

"..I believe this matter pertains to both partners, so I invite them both come and get informed. Usually, they come to ask for the pill, which makes it clear that the pregnancy aspect is taken care of, but sexuality is much more than that, and responsible sexuality means taking care of yourself and of the other person. One takes an egalitarian positiion, not a feminist position: if sexuality is a matter of two, then, preventing unwanted pregnancies and STDs is also the responsibility of both partners. She can take the pill and feel safe as regards to pregnancy, but he also has to take the necessary precautions...well, if she does not have a steady partner she has the right to ask him to use a condom” (Female, physician, 42 years old, Argerich Hospital).

Providers in general, and particularly psychologists, are worried about the fact that, though preventive work is carried out and information is provided, adolescents are conflicted about using a birth control method. One of the psychologists said*:*

"Sometimes they do not react until they get scared by, for example, a delay in their period. Then they see it differently. Understanding the information is quite difficult, that is one of the problems of birth control. It is as if the starting point for understanding was some subjective condition, which makes it very difficult to follow a general strategy. This does not mean you don’t have to inform them: you have to, in the best possible way and without forgetting any detail" (Female, psychologist, 36 years old, Argerich Hospital).

According to one of the professionals interviewed, one of the obstacles in the use of birth control methods has to do with:

"the fact that sexuality is not openly talked about. Adolescents do not have a place or the time to develop and mature their sexuality freely....It is very hard to ask an adolescent to become responsible for birth control if there has not been previous work since childhood. Fear and frustration may play against them in the first sexual relations. They have to try to keep their erection and at the same time they must wear a condom, without having the necessary intimacy and foreplay with their partner, so as to incorporate it as something they should do together. Maybe if there was more freedom or care, kids could reach adolescence being better informed" (Male physician, 33 years old, Argerich Hospital).

Regarding continuity of use, providers referred as obstacles the widespread idea that

hormonal methods cause weight gain, and male resistance to use condoms on the basis that they are uncomfortable and reduce sensibility. Other reasons that would explain why adolescents stop using birth control methods have to do with lack of access to them, and also with certain “fantasies” about motherhood, which in some cases is perceived as the only opportunity to have something of their own (meaning a personal project). As one of the psychologists said:

“A few days ago I saw the case of a girl who, since her sister and one of her friends had had babies, she also wanted to have one. What we do as prevention is try to make them adopt a birth control method and keep on using it" (Female psychologist,56 years old, Rivadavia Hospital)

Another interviewee explains: “First they do not know what to do about the pregnancy, but later they realize that it is the first time they have something that is really their own, which nobody can take away from them, and which will be with them for the rest of their lives”. (Female psychologist, 32 years old, Rivadavia Hospital).

For most providers the “ideal method” is combining the condom with spermicides such as foam or suppositories. This way the boy and the girl are both assuming a responsibility. Providers consider it is very difficult to get adolescents to use “dual protection” (meaning simultaneously preventing unwanted pregnancies and STDs/HIV/AIDS). Initially they believed the problem was economic, but then, when condoms were given away for free, they realized that the rejection of the condom was more related to certain cultural barriers. Adolescents often argue that using condoms is uncomfortable and embarrassing. Their level of awareness of the risks of acquiring STDs is very low, which can be partially attributed to an attitude of denial and an omnipotent feeling -“It will not happen to me”- common in this age. Therefore having knowledge and information about HIV/AIDS and unrestricted access to condoms does not guarantee that they will be used.

In the words of one provider:

“Here condoms are not used, there is no way, its use is not common. Those girls who have a personal life project demand it, but for Paraguayans, Peruvians, Bolivians, and people from the provinces (Salta, Jujuy, etc.) the condom does not exist. There is a lack of decision making power on the part of the girls who consider coitus interruptus as the way to be protected" (Female, physician, 38 years old, Argerich Hospital).

Providers say that most patients are afraid of getting pregnant, but do not see themselves at risk of acquiring AIDS or STDs. Patients believe that if their partner “*is a clean boy, from a good family, then there is nothing to worry about".* The general strategy applied by providers is to prescribe a female method to be used in combination with

condoms. The diaphragm is rarely recommended for teenagers since it is considered to be difficult for them to use because requires being very careful.

Aware of the difficulty of adolescents in using “dual protection,” physicians tend to prescribe pills knowing they need to work more on STDs/HIV prevention. Psychologists, on the other hand, think that physicians do not put enough emphasis on dual protection and STDs, HIV/AIDS prevention, and that when it comes to contraception they favor the pill over the other methods:

“...the pill seems to be the most common method. I do not know whether it is because they are given away for free at the hospital and this economic aspect makes adolescents use them more. They are given the pill, shown the other side of the blister, told to start on a certain day and follow the arrow, and it is easy. But it is easy if the girl does take it, and there comes into the scene the adolescents’ reality, how they handle time, their omnipotence and idea of control". (Female, psychologist 34 years old, Rivadavia Hospital).

Similarly, another interviewee argued:

“I would not put so much emphasis on the use of the pill, while I would on the use of the condom. I think we have to work on the use of the condom. They (adolescents) do not use both. When patients take the pill they do not use the condom, `take the pill, wear a condom!´ the resulting feeling is `Do I need to do all this?”(Female, psychologist, 44 years old, Rivadavia Hospital).

4.2.2. Pregnancy

Neither of the two services provide prenatal care or deliveries. Once a pregnancy is confirmed and after the routine lab work, the patients are referred to the Obstetrics Service and told to come back after delivery for a follow-up and birth control counseling. In the case of the Argerich Hospital, patients are referred to an obstetrician who is exclusively in charge of their follow-up, and who shares the ideological point of view of the Adolescents Service. Patients who need psychological support are referred to the psychologist assigned by the Psychopathology Service. At the Rivadavia Hospital, patients are referred to the Obstetrics Service where the staff shares the same concept of adolescent integral health.

“Our job is to offer support to the patients who become upset when they find out that they are pregnant and don´t know what to do about it” (female, psychologist, 44 years old, Rivadavia Hospital).

4.2.3. Abortion

As abortion is illegal in Argentina[24] the public health services are unable to provide them. Yet, and particularly in the case of adolescents, abortion is often requested at the hospitals.

The staff´s generalized criteria is to talk with the patient about her pregnancy and how it happened. In some cases, the family is called (if she has one), so that the decision could be taken with the best possible knowledge of the factors that are at stake for the patient. Obviously, the final decision belongs to the patient.

In case the patient chooses to interrupt her pregnancy, no referrals are made. However, she is warned about the possible health consequences of an abortion and advised to go to a doctor´s office and not to the traditional healers or other people who offer low cost abortions that are performed in unsafe conditions. Some staff members also instruct the patients to take antibiotics after the procedure.

But most important of all, and as mentioned by one interviewee:

"Our position at the service (Argerich) is to leave the door open, independently of the decision taken, so as to allow for them to come back, both if she decides to go on with her pregnancy or if she decides to interrupt it. We are not in a position to condemn her because then we would loose the patient, and then she can fall in somebody else's hands, not get the necessary help, get infected and put her life at risk" (Male, physician,48 years old, Argerich Hospital).

The intention to work on preventing abortions is clear as one doctor tells a patient after she had an abortion: :

"I think you took a high risk with this birth control method (abortion), you exposed your body too much, we will try to avoid it in the future" (Female, physician,42 years old, Argerich Hospital)

4.2.4. Sex Education

At the Rivadavia Hospital the Information Groups are seen by providers as facilitators of their work. As an interviewed person said:

"The fact that adolescents can ask questions and clear doubts among peers makes our work easier" (Female, physician,49 years old, Rivadavia Hospital).

[24] In relation to the penalization of abortion, the Penal Code has two exceptions: if abortion is practiced to save the woman's life or if the pregnancy is the result of the rape of a mentally ill or insane woman.

The Information Group is very important since it deals with the adolescents' questions, by using puzzles on the female reproductive system, and informing on birth control methods. The Group is also considered to be important because adolescents perceive it as an additional way in which services provide care and support. Exposure to different life experiences helps girls to question many myths about sexuality and birth control methods.

In the case of the Argerich Hospital, different strategies have been tried over the years, depending on the availability of resources. When the Argerich Hospital Adolescents Service was developing the Kellog-supported project they had communication and education activities in the waiting room as well as information groups. At present, information is provided exclusively by the doctor and the psychologist, who also hand out brochures with information on contraceptive methods.

4.2.5. Violence

In general, the services do not specialize in dealing with violence problems, but to some extent they address it since violence is considered to be a health problem. As one of the interviewee said:

"Our integral attention criteria makes us look into a field much wider than the exclusively organic one. Thus, we worry not only about the physical problem, but also about other things: if they go to school, if they live with their family, if they are street children, if they have been expelled from home or from school, if they are being violently treated, if society is treating them violently, if they are being punished or physically beaten, etc. This is a place where you can not force people to talk, but we must have this open space for adolescents to talk. It is very clear that we must use much more than a stethoscope to listen to our patients. We have to listen to many things, and give answers. When we find a violent situation, we have to work individually on each case. I don't agree with sending every case to the Violence Service. You have to be very careful and flexible on these matters" (Male, physician, 48 years old, Argerich Hospital).

In the case of the Rivadavia Hospital, these problems are dealt with as high risk situations by the whole health team, and they are approached from an inter-disciplinary point of view, where each professional contributes with his/her specific knowledge to better understand the problem. Given the increasing number of cases and the greater social visibility of the issue, a psychologist who received special training in violence was incorporated into the team. One of the doctors interviewed said:

"These are situations that really move the group, that produce hate and rage, and a desire for reprisal. They are situations that infuriate the team. That is why working in an inter-disciplinarian way is so important. These are very complex matters because there is little support for staff members". (Male, physician, 45 years old, Rivadavia Hospital).

They work with the family trying to break up the cycle of violence. When needed, and with the help of the social worker, the cases are referred to the corresponding court of law. In the past, victims had to be examined by a forensic doctor but at present it is enough with a report from a hospital doctor. This has sped up procedures and encouraged people to report cases of violence, since they do not feel they have to go through an extra embarrassing stage.

4.2.6. Substance abuse (alcohol, drugs)

Neither of the two centers specializes in treating substance abuse. At the Rivadavia hospital few cases have been detected and providers suspect that they are having problems in identifying these situations. When a case is detected, the adolescent is provided individual psychological assistance. If the case is severe, the patient is referred to a specialized institution that shares the team's criteria.

At the Argerich Hospital, where the incidence of addictions is higher, providers see the problem as a very complex one. Providers there have received special training so as to be able to deal with substance abuse. Regarding alcoholism, when there is a specific demand for help, the patient is sent to AA (Alcoholics Anonymous), a group that works within the hospital. There, self-help groups are formed and patients receive psychological assistance focusing on the understanding of the causes that led to the problem.

The problem of drugs is much more complex, because, generally speaking, the demand "for help" is not an explicit one. As an interviewee said:

"You can detect it, but the patient who is in the process of "falling in love with the drug", does not want to leave it. As a matter of fact, drugs are taking the place that society, family, school, friends, whoever, does not want to give to the individual. Thus, it is not easy to keep these patients within a hospital environment and there are not enough good public services to have the patients sent to. Then, taking care of these demands is even a risk, a difficulty". (Male, physician,48 years old, Argerich Hospital).

Drug addiction is an issue difficult to be asked about during the medical interview, and it is necessary for the professional to be instructed to avoid blaming the individual either verbally or through gestures or attitudes. One of the doctors interviewed said:

"knowing the high prevalence in the use of drugs, you try to approach the subject in a "natural" way, such as asking when was the last time they tried it, and from there on you can try to untie the knot. The fact that they do not talk much shows how difficult it is to deal with these problems or with homosexuality. They are difficult issues for adolescents" (Male, physician, 33 years old, Argerich Hospital).

4.3. Community-based activities

For both services, the relationship with the community has been a complex and intermittent one. In the case of the Argerich Hospital, during the 1992-1994 project supported by the Kellogg Foundation they carried out a multi-disciplinary activity working in schools, orphanages, and a house where commercial sex workers live, trying to attract a population that is usually hard to reach for health services. Some links with these populations continue today. For instance, two time slots are saved by the Ambulatory Care Room each day in case street children drop in. Since these are considered "high risk" cases, any contact with the Service is considered an opportunity to provide them with a general medical examination. The Argerich Hospital staff also mentioned that other neighborhood institutions send them patients with problems related to alcoholism, drugs or violence. Providers declared that the main obstacles to carrying out health activities in the community are bureaucratic restrictions (lack of permission to leave the hospital during working hours) and economic constrains (lack of human resources and materials).

The Rivadavia Hospital does not have as long a history of relationship with the community as the Argerich Hospital. Yet, they had developed very important contacts with recreational and sports clubs (patients are granted scholarships to practice some sports), art workshops and schools among other organizations. These activities stopped in 1998 when the team lost the social worker and the sociologist due to budget cuts (at present the Service has to resort to use of the Social Work Service that serves the demands of the entire hospital). Still, since the Adolescents Service is well-known in the community, providers are confident that schools and neighborhood institutions consider it an accessible resource.

4.4. Health providers satisfaction with their job

The majority of the professionals interviewed were satisfied with their work and acknowledged their satisfaction as a job "facilitator." Without exception interviewees mentioned how important it was to belong to an inter-disciplinary group, for this allowed them to learn, to become informed, to participate in conferences, to do research work, and to carry out external supervision among other activities. Having the chance to exchange ideas with colleagues and the ease of mind that results from confronting serious and complex cases together were also positively valued. One respondent said:

"Working as a team makes you feel that you speak the same language, and suddenly you don't have to say much. You know what the other person thinks" (Female, physician, 42 years old, Argerich Hospital).

The fact that both Chiefs of Department promote activities and do not put obstacles to team work seems to contribute to a positive work environment. Other reasons for satisfaction mentioned were: the prestige and identity derived from belonging to a well-known service, having the chance to learn and become updated, and the possibility of working collectively and with a preventive approach.

Among the lessons learned, interviewees mentioned the development of negotiating skills and how to handle pressures. As one interviewee said:

"You try to avoid becoming a municipality employee" (meaning making the job something merely bureaucratic)" (Female, physician, 38 years old, Argerich Hospital).

All of the interviewees mentioned that patients´ gratitude could be considered as one of the motivations of their job. One of the female doctors interviewed, for instance, mentioned how touched she had felt when one of her patients named her child after her, to show how thankful she was for everything the doctor had done for her.

4.5. Obstacles faced

Almost all the people interviewed mentioned structural problems at the hospitals; lack of materials and human resources and problems with laboratories, which affected the process and timing of diagnosis.

As one of the interviewee said

"The system is very perverse. I have been coming here to work for free for seven years. Coming to work for free is my decision. Nobody forces me to do it, but sometimes it is very difficult, because there are many restrictions. Due to the lack of resources the decisions, the diagnostics, the treatments are affected. And so you face an obstacle that, no matter what you do, you can not overcome. Then, the hospital gets impoverished and the people worn out". (Female, physician, 33 years old, Rivadavia Hospital).

Another obstacle mentioned was that due to lack of money to pay for transportation patients do not reach the hospital or do not comply with treatment. Professionals also complained about work overload, since they need to have several jobs:

"The best situation would be to earn, in only one job, enough money to live, and be able to work full time at one place, but this is not so. And this is an important obstacle. Having to be in one place, knowing that you have to go to another and that the previous night you were on call and had to work the night shift. These are all elements that affect the quality of your work: the possibility of giving more time and dedication to each patient, of carryimg out research, of teaching, and not be limited just to responding to the demand" (Male, physician, 33 years old, Argerich Hospital).

Another problem identified, particularly at the Argerich Hospital, was the uneven distribution of work load between the different shifts (with doctors working in the morning

hours having the highest amount of patients) and the diversity of tasks physicians perform (service delivery, training of medical students, filling out forms and producing reports among other tasks). In addition, interviewees highlighted the difficulty of performing work without any administrative support and with very few and poorly trained nurses.

Finally, the fact that there is no program on adolescent health (or adolescent reproductive health) in the City of Buenos Aires poses additional problems given that existing legislation prevents physicians from providing services to adolescents without parental consent. Mentions were made to the fear of legal demands and to the inconveniences caused by the absence of specific guidelines. As mentioned above, the way in which teams have worked out solutions is by notifying parents in cases where patients may be at risk. In the rest of the cases the criteria is to provide information and contraceptive methods to adolescents who demand it, claiming the procedure falls under “professional confidentiality”.

As regards the National Plan only some of the interviewees where aware of its existence. The ones who did know about it agreed with it but said it was difficult to implement the holistic health criteria when there are no specific guidelines for service delivery.

Chapter 5. Health care from users' perspectives

5.1. Sample features

Thirty interviews with patients were conducted in the two Adolescents Services selected for our research, of which only three were males. Interviews with the females were carried out in the two hospitals proportionally, while the interviews with males were conducted at the Argerich Hospital because it is only in this hospital that patients of both sexes receive medical health care. The small number of males in the sample reflects the much lower number of medical visits by males in comparison with females; this was clearly observed during the period of fieldwork.

The age of the interviewees ranged between 11 and 20; the majority of the subjects fell between the ages of 15 to 20, with a strong concentration (approximately 66% of the total sample or 20 interviews) between the ages of 18 and 20. Most of the patients interviewed were single, six lived in consensual unions and three were married. Most had no children and not all of those who did have children lived with their partners.

Sixty percent of the patients interviewed were born in Buenos Aires and the Greater Buenos Aires Area while 40% were immigrants. Immigrants came in proportional shares from other provinces or from neighboring countries. All of the patients interviewed had been exposed to formal education. Most patients interviewed had either completed elementary school or had attended part of secondary school. Four subjects had not completed elementary school, two were in elementary school, other two were enrolled in vocational education and one was attending the university.

Twenty out of the thirty interviewees (66%) said that they did not work, and that the money they need for their expenses was provided by their parents, their partners if they were married, or their boyfriends. Those who worked had, in the majority of the cases, temporary and unsteady jobs.

Sixty-six percent of the interviewees declared a religious affiliation but without any kind of religious practice. Nineteen defined themselves as Catholics and one as Evangelical. When asked about the influence of religion on their reproductive patterns and health care the majority of the subjects found no relation whatsoever.

A small number of respondents, though, thought otherwise, as reflected in the following response:

"I think that religion bears upon health care because, for instance, in the church they give lots of talks about drugs and all those things that affect youth" (Female, 17 years old, Rivadavia Hospital).

"Religion affects health care because I always ask God and the Virgin Mary to protect my son, my husband, my mother and my family" (Female, 20 years old, Rivadavia Hospital).

One interviewee explicitly mentioned the influence of religion in the case of unwanted pregnancy.

"I told her (a friend of hers who had gotten pregnant) that even if I am a Catholic I would not have the baby because I have many plans for the future and motherhood would certainly be an obstacle to my plans. However, afterwards I thought it over once again and said no, if I am all right with my partner it is better to have the baby". (Female, 19 years old, Rivadavia.Hospital).

5.2. Acquaintance and relationship with the health service

The reasons reported by users for choosing the Adolescents Services included proximity to the patiente's home (this is especially the case of some of the patients of the Argerich Hospital who have a strong identification with their own neighborhood). A patient said that

"I spent all my life in La Boca, and I know the hospital as if it were a part of my home" (Female, 16 years old, Argerich Hospital).

Others go to the Adolescents Service because somebody they respect recommended it (i.e. mother or aunt who was hospitalized). Only a few in the sample said that they had selected the Adolescents Service because of its comparative better quality vis a vis other medical units.

"Where I live [Florencio Varela, a empoverished disctrict of the Greater Buenos Aires area] is much more complicated because hospitals lack things necessary to treat the sick. They lack doctors and then you go, they see you, but the problem is not solved. They just see you to get rid of you. Here things are different and you notice it. They work in a different manner" (Male, 20 years old, Argerich Hospital).

All the patients interviewed have had a relatively long relationship with the Adolescents Service, and can express opinions and make evaluations about the questions asked in the interview. For instance, regarding working hours the majority of those interviewed answered that the morning hours were very convenient, especially for those who had a job. In the case of students, convenience depended on their school hours. All of the patients interviewed criticized the long waiting hours they had to face before being seen by a doctor, especially in the Argerich Hospital where in order to get an appointment with the doctor –known as "el turno"– they must show up early in the morning, around 6:00 a.m. Given that doctors see their patients beginning at 8:00 a.m., the total waiting time until the doctors call the patients can easily extend over four hours. In many cases, the patients say they have to wait for their number ("turno") until noon.

Although complaints about the long waiting time are almost universal, in some cases the criticisms are tempered by the satisfaction expressed for the good quality of care and the kindness of the medical staff. In other cases the patients are also very critical about the health care received. According to two females:

"I have to wait a long time. Sometimes the "turnos" are mixed up and the people who came last are seen first" (Female, 19 years old, Rivadavia Hospital).

"Sometimes they see you real quickly and sometimes the doctors make you wait for hours. This depends on whether they want to work or not. They may be in their offices doing nothing while their patients are waiting" (*Female, 18 years old, Argerich Hospital).*

Many of the patients who do not live in the neighborhood spend up to two or three hours travelling to the hospital in public transportation, and then they have to wait a long time until they are called by the doctor. This implies that the patient may invest up to eight hours or more in order to be seen by the doctor.

5.3. Reasons for consultation

According to the patients interviewed, the most frequent manifest reasons for consultation are: alterations in the menstrual cycle, delayed menstruation, pregnancy, contraception, abdominal pain, vaginal discharge, gastrointestinal problems, seasonal diseases (flu, colds, allergies, etc.), and headaches among other complaints. In addition, other types of demands related to sexuality emerge. In the sample, only one patient explicitly went to the hospital because of sexual violence, and she did so because of the recommendation of an acquaintance. Other cases of violence were detected during psychological and medical follow-up This shows the difficulty of expressing sexual violence as a manifest reason for consultation, a problem that is frequently reported by the doctors.

In the majority of the cases, patients said they go to Adolescents Services alone. Only those younger than 15 said they were accompanied by one of their parents. Several women were accompanied, especially during the first consultation, by their partners. Later on, they continue to go by themselves because of the conflicting schedules between the hospital and the working hours of their partners. The patients said that they were happy with the company because they felt more secure, but they seemed to be quite capable and used to solving the problems by themselves.

5.4. Perception of the adolescent's health problems

Our goal was to detect the perceptions that teenagers have about their health and their main concerns regarding health problems. In order to address those issues, questions were formulated in hypothetical terms ("suppose a friend of yours…"), and the answers were given in the same way with very little personal involvement: (i.e. "there are girls who can have an abortion without problems" or "other kids consume drugs").

In the words of an interviewee,

"at that age, nobody thinks too much about health, but still I'm worried about AIDS and drugs because both are getting more and more customary and people care everyday less and less" (Female, 19 years old, Rivadavia Hospital).

Generally speaking, most of the worries, even though non-specified, hinged around sexuality:

"all the concerns relate to the theme of sexual relations" (Female, 16 years old, Rivadavia Hospital).

There are explicit references to the need of ensuring adequate levels of sexual education and information, and in this regard the health services involved have a very important role to play.

Eating disorders are not perceived as health problems, although doctors regard them as such. One interviewee refers to this issue by saying that *"there are people who eat nothing".* Two others said that "hysteria" is a health problem:

"people get nervous because of lack of time. This brings psycological problems that prevents them from being good parents and jeopardizes their development as human beings" (Female,19 years old, Rivadavia Hospital).

The overwhelming majority of adolescent concerns had to do with pregnancy, abortion, contraception, HIV/AIDS, violence, drugs, alcoholism and other addictions and sexually transmitted diseases.

5.4.1. Pregnancy

Pregnancy is seen as a very worrying theme given the high percentage of teenagers having an active sexual life and the scarce information available on contraception and prevention. For one interviewee the reason is that:

"At my age we are all kids, what can we do with a child?" (Male, 19 years old, Argerich Hospital).

The axiological perspective and possible solutions to an unwanted pregnancy substantially differ according to social class and educational level. In most cases pregnancy is accepted as a possible risk that calls for different strategies to face it. The appeal to the understanding and help of the family is a frequently used resource in these cases. Although girls are fully aware that boys frequently refuse responsibility for the problem, they tend to argue in favor of shared responsibility. Even in the words of a boy interviewed, it becomes clear that shared responsability is more a desire than a reality.

"I think that from the moment in which you have a relationship with another person there is a common agreement. For instance, when a girl gets pregnant both start to blame each other. But it is not the responsibility of just one member of the couple. In the majority of the cases the boys disappear and the girl cannot get rid of the problem so easily" (Male, 20 years old, Argerich Hospital).

It was quite clear in the interviews that women cannot avoid the responsibility:

"in the majority of the cases the woman has to take care of the whole thing, and the relationship with the man ends, and the girls remain hurt and abandoned. It is terrible when a man whom you love does that! It's an enormous pain, a wound that can not be healed" (Female, 17 years old, Rivadavia Hospital).

In some cases certain contradictions and doubts appear in relation to the conflict between their own personal goals and teenage motherhood.

"Often the parents (meaning the girl´s parents) don't want the baby. In other cases the boyfriends (or their peers) don't want the baby, Sometimes the girl does not want to have the baby because she feels she is too young and wants to continue her education; but the Church says that abortion is a sin. Abortion is not only a girl's problem but a male's problem as well" (Female, 17 years old, Argerich Hospital).

Both Adolescents Services work in pregnancy prevention, and when the girl is already pregnant they try to explore all the possible options aiming at building bridges with the girl's family in order help her in such a critical moment.

5.4.2. Abortion

All the interviewees declared themselves against abortion as a solution to unwanted pregnancy. Only in two cases did the subjects express hesitation, and this was when an eventual pregnancy would stop the development of a planned life goal.

It is interesting to analyze the critical assertions regarding abortion, which contradict existing epidemiological data on the incidence of unsafe abortion in that age group. It appears that the anti-abortion discourse does not necessarily match the ongoing social practices.

The patients' arguments are as follows:

"It is the worst thing that can be done to anybody. It's a tiny little thing that has nothing to do, that is blameless, and that didn't ask to come to this world" (Female, 18 years old, Argerich Hospital).

"It doesn't matter if it has neither head nor feet nor nothing. It is to kill a person!" (Female, 18 years old, Argerich Hospital).

"Those who abort are crazy. They destroy human life" (male, 17 years old, Argerich Hospital).

"You can't kill like that an unborn creature" (Female, 16 years old, Rivadavia Hospital).

As can be seen, this discourse does not significantly differ from the traditional discourse of the Catholic Church in defense of the "right to life" from the time of conception.

In some responses, moreover, the rejection to abortion appears as a moral condemnation towards those who practice it:

"if you enjoyed sex you must have the baby now!" (Female, 18 years old, Argerich Hospital).

There are also some considerations of the different risks involved in an abortion due to the conditions under which illegal abortions are performed:

"Abortions are made like nothing, as lightly as when they get pregnant for not having thought of the matter beforehand. When they (the females) try to get rid of the whole thing they don't think that they can end up in jail" (Female, 20 years old, Argerich Hospital).

Regarding a friend of hers, one female mentioned that:

"She must not do fooleries, like getting rid of the kid or giving him away in adoption and then regretting it . I'll punch her on the nose if she tries to get rid of the kid!' (Female, 19 years old, Argerich Hospital).

In other cases, there were references to the biological or psychological risks involved in abortion:

"sometimes things seem to be all right and later on the problems start. For instance, a girl of 15/16 years that has an abortion now, how could she react at age 30 or 40 if she thinks that her daughter would be a teenager then? In addition there are girls who have bad abortions and risk not only the baby's life but also their own. Sometimes the abortionist does not 'clean' her well" (Female, 19 years old, Rivadavia Hospital).

5.4.3. Contraceptive methods

Even though contraception is not viewed as a health problem, there are references to the concern and difficulties raised by the lack of information about pregnancy prevention. In the majority of the cases, the individuals have some degree of knowledge about the contraceptive methods and underline the role played by the hospital doctors in

informing and explaining their contraceptive options. The Adolescents Services are viewed as:

"A good place because they provide oral contraceptives free of charge" (Female, 17 years old, Argerich Hospital).

The majority of the sample asserted that it is better to use contraception when having sexual relations so that pregnancy is not the result of chance but of an explicit desire. Yet, this explicit intention not always corresponds with their real life situations: the strategies supposedly adopted to prevent an unwanted pregnancy seem to be more linked to contingent factors, like the access to oral contraceptives and the fact they are easy to use ratter than to a careful selection of the best contraceptive method.

Some interviewees mentioned that their male partners refused to wear condoms . When females request the use of condoms some male partners interpret this as lack of love or as mistrust. In addition, they argue that condoms are an artificial barrier that prevents "feeling really close". A few subjects, however, underlined the irresponsibility of having sexual relations with occasional partners without condoms given the serious risks of contracting AIDS.

5.4.4. AIDS

In all the interviews, AIDS was viewed as a very serious health problem since it is a life threatening disease. Yet, once again, the practices of adolescents and young adults of both sexes were, in many cases, inconsistent with their discourse. They perceive the risk to their health, but they claim to have received little information on AIDS from the Adolescent Services except when they explicitly requested it. However, they have managed to obtain some information by other means, such as the school, television, and their families and friends.

Serious confusion was detected in the information about AIDS that adolescents and young adults have, however, some discriminatory attitudes were noted as well. In the words of a patient:

"People believe that it is only a disease of Haitians and transvestites. However, there are travestis that are very careful. There are lesbians and transvestites that are very thoughtful and careful about AIDS, despite of the dirty things they do. Nevertheless, there are people who are heterosexual that are even dirtier and sicker than the former" (Female, 19 years old, Rivadavia Hospital).

5.4.5. Sexually transmitted diseases

Sexually transmitted diseases (STDs) are not perceived as a health issue, and there is confusion regarding the available information. A female interviewee who had an acquaintance who suffered a miscarriage entertained the idea that:

"Perhaps the cause may have been syphilis, or maybe the baby infected the mother with syphilis. People say that because it is widely known that her former partner had sexual intercourse with dogs" (Female, 19 years old, Rivadavia Hospital),

In general, all the interviewees had little and inaccurate information about STDs (except in the case of AIDS), how they can be transmitted, their consequences, prevention and treatment. In relation to information, a female interviewee recognized that:

"I don't have any information on 'that' (meaning STDs); there is lots of information on AIDS but not on other diseases that even if they are not life threatening they are still diseases" (Female, 18 years old, Rivadavia Hospital).

5.4.6. Violence

Patients perceived sexual, domestic and social violence as a problem affecting not only teenagers but society as a whole. Several individuals in the sample expressed concern that violence was becoming a generalized and extended phenomenon. A male interviewee commented that the increase of violence is related to social marginality and discrimination.

"Society places discrimination of the young [his hands separated widely in a gesture of separation] because they say young people are drunks and drug addicts. But one has to look into what happens in the family. Parents marginalize their children too. The violence of the young is related to the way in which the elders have acted" (Female, 17 years old, Argerich Hospital).

Another female said that:

"If a kid grows up in a violent environment the only thing he can learn is violence" (Female,18 years old, Rivadavia Hospital).

Sexual violence is definitively a terrible problem that bears grievous consequences for any individual. According to one interviewee:

"My stepfather repeatedly raped me when I was a little girl. I'm going to have sexual trauma until I die. I will not be able to have children or even a relationship with a boy because I'll be scare to death!' (Female, 18 years old, Argerich Hospital).

Most individuals expressed their doubts that the Adolescents Service could be the appropriate place to deal with violence, and suggested that there should be other specialized agencies or institutions from which to seek advice and protection. One female mentioned the link between adolescent pregnancy/parenthood and violence . In case of an

unwanted pregnancy, when the baby is born and the adolescent parents move in together, situations of domestic violence can arise, fueled among other things, by the high consumption of alcohol by males. Again, as with other issues, lack of information and knowledge about what to do in case of violence emerged among many interviewees. One female said that:

"When you are in that situation you don't know where to go, whom to address for help. Nothing, you know nothing and you don't know what to do". (Female, 20 years old, Argerich Hospital).

5.4.7. Drugs and alcohol

The majority of interviewed patients expressed concern about the growing consumption of drugs and alcohol. However, despite the fact that adolescents assert that they themselves do not use illegal substances, interviewees revealed a certain familiarity with drugs:

"Every day it is easier to get drugs, everybody tries them" (Female, 18 years old, Rivadavia Hospital).

"*You are in an age in which you take whatever is at your reach. If they give you a cigarette you grab it because you want to see what happens" (Female, 18 years old, Rivadavia Hospital).*

Drug abuse and alcoholism are seen as social and individual problems, but not as health problems. The interviewees do not think that health care services in general have any responsibility in these matters. Some of them mentioned community institutions that deal with these issues but all of them insisted that the problem can only be solved if the individual wants to get cured. Discourses reveal a certain omnipotence and an adolescent belief that the drug addict and the alcoholic can control his or her dependence. One of the subjects framed the problem of drug abuse in close relationship with education, and said:

"Drugs are not a problem of the youth only but of society at large because AIDS is less a matter related to sex than to drugs. Seventy percent of the HIV-infected people are infected because of drug consumption. It's a difficult problem to solve because it would be necessary to change the mentality of the entire world!" (Male, 20 years old, Argerich Hospital)

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It has to be underlined that this was the only person in the sample of patients who established a relationship between health and drug and alcohol addictions.

5.5. Satisfaction with the medical health care

The majority of the sample of patients expressed not only satisfaction with, but also surprise at, the quality of the medical services provided by public institutions. To understand this, it is important to point out that in Argentina, the public hospital has been

traditionally regarded as the place where the poor and needy seek medical treatment. As mentioned in Chapter 1, with the economic crisis this perception has changed dramatically as a growing number of patients from the middle classes have started to combine use of public hospitals with those services provided by their private insurance or the union's "obras sociales."

A female user said that she would strongly recommend the hospital because of the quality of its medical service:

"I was really surprised. I had expected something different from a public hospital, something more crowded and disorganized. As far as the personnel is concerned it looked very good to me... In the Adolescents Service they pay attention to all the problems and see their patients with care" (Female, 19 years old, Rivadavia Hospital).

Regarding the quality of the medical health care, one female user was pleasantly surprised when she realized that the response of doctors and nurses greatly exceeded what she had demanded. The staff directed her to take a series of interviews with a psychologist because her medical problem (alterations in the menstrual cycle) also had an emotional origin (recent migration).

"In other cases", she said, "they say to you take your clothes off, sit down, and come back to pick-up the results in such and such day and that's it. You have such and such disease, take this medicine and you will be all right then" (Female, 20 years old, Rivadavia Hospital).

As mentioned above, the majority of the people in the sample said that they would recommend the service because:

"if you need something the lady doctor will kindly help you. And the psychologist, if you happen to be in trouble, she will encourage you and calm you down instead of reproaching you for your supposed wrongdoings" (Female, 19 years old, Rivadavia Hospital).

This satisfaction with the medical health care is a recognition of the capacity of the whole team:

"I get information from other places, but for me what they tell me here is sacred word, because they know much more than anybody else" (Female, 18 years old, Rivadavia Hospital).

Despite this wide spread opinion regarding the quality of the medical attention, a few interviewees took pains to point out that the quality of the service largely depends upon things such as the mood of the doctors. One patient said that:

"the first time I came here to have a colposcopy and I disliked it very much. The lady doctor made a very rude comment. She said "they sure have stuck many things in here" (meaning her vagina) and I was pissed off. But the next time the same lady doctor saw me again and she was very nice" (Female, 18 years old, Argerich Hospital).

In the same way, some patients asserted that the clarity and quality of the information received varies depending upon the doctor in charge. One patient reported that:

"They don't explain anything to me. I ask them and they don't even bother to answer me. For instance, I underwent a colposcopy and the lady doctors would only talk among themselves. They don't answer what I ask. Why do they refuse to tell me what is going on, what is wrong. Why don´t they speak clearly and not with those strange words they use to talk each other?" (Female, 18 years old, Argerich Hospital).

The same patient concluded by saying she didn't ask any more questions because the doctors never answer.

The experience of other patients is quite different. Some of them said that they can pose questions to the doctors and that in exchange they receive good explanations:

"in a language clear and straightforward, that I could understand, and not with the words that they use" (Female, 20 years old, Argerich Hospital).

In some cases the patients mentioned as a factor which could prevent a better dialogue between doctors and patients the stressing working conditions prevailing in public hospitals where doctors have to see too many patients and cannot pay attention to the problems of everybody.

At the Rivadavia Hospital, most people interviewed valued the existence of the Information Groups as a place where it is possible to speak with health specialists and ask question on a variety of issues related to sexuality. Finally, the females of the sample generally stated that for gynecological exams and visits they prefer to be seen by female doctors rather than by male doctors. They feel more confident and safer with the former, and in addition, the lady doctors are supposedly better prepared to understand women´s problems.

5.6. Privacy and Confidentiality

Most interviewees made some interesting observations on the material conditions that prevail in the hospitals that can undermine the necessary privacy during the medical visit. Since there is no real division between offices, even when the patients are alone with the doctor, next door other people are being examined or waiting to be called, which makes the patients feel uncomfortable and afraid of being heard by strangers.

"What if someone is sitting in the contiguous box? I thought: wow!, she is going to listen everything I say!" (Female, 18 years old, Rivadavia Hospital).

Another factor which interfered with the privacy during the medical visit was that other people besides the patient and the doctor were sometimes present in the doctor's office. The interviewees accepted, however, that these unexpected third parties were medical students doing their residence at the hospital and that their presence would not jeopardize their privacy.

Some female patients, though, voiced the discomfort they feel in some occasions because of the lack of enough privacy.

"I'm surely bothered that when they are doing a Pap smear, for instance, there are people who open the door and pass through the doctor's office. It is necessary to have more intimacy. People entering and leaving while I'm in the office drives me crazy" (Female, 18 years old, Rivadavia Hospital).

Concerning confidentiality in the patient-doctor relationship, the interviewees trusted that the medical staff would not disclose any confidential information. For example, in a situation of an unwanted pregnancy a patient remarked that:

"If a friend of mine needs medical advise she should come here, because she will be just one more in the lot. In the labor union medical insurance (the "obra social") instead, they have contact with her parents" (Female, 18 years old, Rivadavia Hospital).

Even though the patient praised the confidentiality of the hospital, her remark can be interpreted from another perspective: on the one hand as a recognition of the reliable level of confidentiality provided by the hospital; on the other hand, as a distressing anonimity that may be the disguise of a little-personalized health care.

5.7. Information, education and communication activities

The interviewees know in a rather vague way the existence of a series of materials containing information on sexual matters, health issues and communication networks. They know there are brochures providing useful information on contraceptive methods and AIDS prevention, but either the materials were not given to them or, they did not read them carefully. They also know that there is an Information Group, but since it is optional, several female interviewees refused to go. Doctors and nurses underline the importance of education and communication in their day to day work, and so do the patients. Yet, patients don't appear to be aware enough of the importance of attending those activities.

A female patient said that:

"They gave me more information because they sent me to the Information Group to talk with several other people. I was shocked to learn that there were people older than me that didn't know what the pills were. I did know what they were, but the additional information was very good. It was more information and I took advantage of it" (Female, 18 years old, Rivadavia Hospital).

When our field work was about to conclude there were small Information Groups being set up in the waiting room of both hospitals. In this way the “dead time” of the patients can be profitably used to provide them with information. However, the efficacy of such groups could not be assessed in this study.

Chapter 6. Final considerations

Adolescence has been widely described as a crisis stage in life, marked by conflicts, doubts and concerns, implying the redefinition of identity in the relationships with the family and peers (Schuffer, 1988 and Siebert, 1999). It is characterized by important physical, hormonal, psychological and emotional changes. Adolescents face challenges within a context of certain economic, cultural and social structures. Thus, adolescent sexuality is embedded in the framework of conceptions and values present in a specific culture.

Postmodern adolescent culture is manifested through a particular way of discovering life and experiencing sexuality, defined by what is fast, immediate and diverse. This is why youth sexual culture is characterized by unsteady and inconstant relationships. It is therefore important to guarantee access to health care and information for the development of a healthy and responsible sexuality.

The city of Buenos Aires presents a peculiar situation. Even though there is no specific Adolescent holistic health program or reproductive health program for adolescents, health care to adolescents is provided in the majority of its 15 public hospitals and in many of their primary health care centers that carry out an important strategy of health care and prevention with this age group.

The conclusions of the present study are focused on the three different levels of analysis presented in the report:

a) The National Plan for the Integral Health of Adolescents
b) The characteristics and functioning of the health care services
c) Health care providers' and adolescents' perspectives on issues perceived as health problems, their satisfaction with health care and their demands and suggestions.

6.1. National Plan for Adolescents Integral Health

Given the lack of programs or reproductive health plans we decided to analyze the National Plan for the Integral Health of the Adolescent developed in 1993. It is important to highlight, as noted by several of the key informants and health care providers interviewed, that within the City of Buenos Aires, the National Plan is taken as a general framework of reference for the health care services.

This study analyzes the National Plan's chapter on reproductive health which contains a series of general characterizations.

With respect to the type of education and information that adolescents receive, the National Plan only posed generically that "adolescents should be able to count with an information service in the mass media oriented towards a healthy and safe practice of sexuality.

No specific mention about contraception is made in the chapter on Reproductive Health but in the general formulation the plan states the need of "privileging a preventive approach in all kinds of attention", which could be interpreted as a recommendation for pregnancy prevention.

The creation of specialized services is not specified in the Reproductive Health but reference is made to how import and essential it is to count with "individualized locations and with interdisciplinary providers trained in adolescent reproduction". This is only clarified for adolescent fertility and not for STD/HIV-AIDS, complications arising from unsafe abortions, victims of violence, victims of sexual abuse or incest.

The chapter on Reproductive Health targets men and women and specifies the need to promote responsibility in sexuality and procreation in both sexes. This enunciation of the National Plan is reflected in the providers' attitudes towards unwanted pregnancy, since they put great emphasis on shared responsibility for birth control between females and males.

Nothing is mentioned on the question of promoting gender equality. Regarding the norms and practices that guarantee free choice for women, the plan recognizes the importance of respecting the adolescents' "decisions (sexual initiation, marriage, giving a baby for adoption) when these are the product of careful evaluation".

No reference is made in the National Plan about the confidentiality of information and informed consent. The law requires parental authorization for minors under 16 for any medical act, although, in practice, it is recognized that this is seldom the case.

The National Plan states the need to have services for adolescents with trained proffesionals who can provide care to this age group, understand their specific problems and train significant others (parents, teachers, etc.). There is an explicit reference to the need to develop interdisciplinary activities at different levels: "actions directed towards caring for adolescent health must have a participatory approach, including the family and the community, with fundamental emphasis on the prevention and promotion of healthy lifestyles". Mention is also made to the need of including "the participation of youths at every stage of the plan".

There is no mention to access to reproductive health care in terms of legal rights of adolescents, but mention is made to the importance of this life stage and the need of adolescents to receive quality health care, respecting their time and privacy. No reference can be found about women's rights to autonomy regarding their decisions about reproduction and reproductive health. Neither are reproductive rights specified as basic human rights, which contradicts the Convention on the Rights of the Child (which was incorporated to our National Constitution in 1994), and the Cairo and Beijing Platforms of Action signed by Argentina. This is an example of the difference that exists between the explicit recommendations to guarantee adolescents' rights to reproductive health stated in the documents produced at the international conferences, and what is actually done by the signing states.

Given the National Plan is a holistic health care program, the importance of the bio-psycho-social wellbeing of the adolescent is highlighted. In this sense, even if it is not formulated in the language of rights, the importance of education, employment, participation, recreation, etc. is present. Among the objectives can be found precisely "to tend toward "equal opportunities" for adolescents keeping the concept of impartiality in mind".

The plan does not express any discriminatory language regarding national origin, marital status, social class or gender and each region is supposed to adapt it to the characteristics of the location and the social and class conditions of target populations.

A linguistic analysis reveals a conceptual framework that poses: a) the importance of adolescent issues emphasizing the need to perceive adolescents as a highly vulnerable group, and b) the need to receive health care from a holistic perspective. The family is considered a fundamental actor in relation to adolescent health and so are peers and the community.

The development of the Adolescent Integral Health National Plan in 1993 marked an important turning point since it established that adolescents are entitled to rights, specially regarding the right to holistic health care. However, this National Plan has not had sufficient impact to promote the creation of a national reproductive health program that incorporates the general recommendations of the National Plan and of the Cairo and Beijing platforms of action.

In the case of the City of Buenos Aires, the lack of reproductive health programs is an important debt to the present and future generations. Different governments have held a narrow view on adolescent reproductive health, influenced by diverse political and

religious interests, and left the contentious issue out of their agendas, therefore putting an already vulnerable population at even greater risk. Within the Argentinean health care system, which is decentralized by jurisdictions, the absence of a reproductive health program for adolescents in the city of Buenos Aires results in the lack of resources and supplies and of general regulations common to all health care services.

6.2. Characterization of Health care services

During the 1990s a major health reform process was carried out as part of wider state reforms, which has had a negative impact on the quality of health care. In the particular case of the Adolescent Services studied here, this became evident through a series of changes which hinder the provision of holistic health care.

The Adolescent Services at both hospitals hold a holistic conception of health which they understand as approaching the human subject as a whole, and considering it a bio/psycho/social being. The notions of prevention, interdisciplinary approach and transdisciplinary exchange are also crucial elements of services' perspectives.

This philosophy, present in the text of the National Plan and shared by the professionals interviewed, is very difficult to achieve in daily practice. In both institutions where the study was carried out, different factors obstruct the delivery of services from a holistic perspective. Some of these factors included:

1) Lack of the necessary human resources needed to provide services in all the medical specializations. Graduate students and interns are no longer allowed to work in these services which implies a reduction in staff.
2) The concept of taking an intersdisciplinary approach is practiced according to the professionals' own will, in a personalized manner with colleagues who share similar criteria concerning adolescent care, and not through institutional mechanisms.
3) The practice of transdisciplinary exchange is impossible to apply since there is no time for exchanges among colleagues or research activities which results in diminished opportunities for training.
4) Institutional frailty in the sense of the absence of a program that regulates health care providers´ collective actions and supports them. The problem of delivering health care to minors without parental authorization is a crucial matter. Providers attempt to resolve this by becoming responsible themselves (particularly with those above 15 years of age) and protect themselves behind professional confidentiality. This is usually a team decision that depends on the chief's opinion on the issue.

5) Governmental and institutional bureaucratic barriers in carrying out the necessary social coverage. Some professionals developed strategies to overcome these bureaucratic barriers: for example in the case of street children, professionals consider such cases as risk situations that should be treated as emergencies where patients must be seen even without an appointment.
6) In both hospitals, logic for evaluation was established on the basis of “productivity” which has resulted in a reorganization of the system of appointments and a reduction in the actual time professional spend with each patient.
7) Compliance with working hours, as well as the filling out of the necessary paper work, are strictly controlled. This allows no time for outreach activities in the community which in turn makes the type of health care provided more curative than preventive. Despite these limitations, providers attempt to dedicate the necessary time to each patient. This is very important since in the case of adolescents it is necessary to create a climate of easiness and spend as much time as needed to explore the different issues that are not straightfowardly expressed in words. Rushing through the visit makes it more difficult to get to know adolescents better particularly regarding sexual practices and other issues like substance abuse.
8) Many staff members are volunteers who receive no payment for their work, and they frequently rotate from one service to another. On the other hand, paramedics receive insufficient training which makes the formation of work teams difficult.

Even though providers in the Adolescents Services at both hospitals have some knowledge about gender they do not necessarily translate this perspective to service delivery. Understanding the gender perspective implies acknowledging the existence of unequal power relations between men and women, especially in sexuality. This means that men and women have different decision-making power in matters concerning their own bodies. This must be taken into account for the promotion of health prevention behaviors. Even though the gender perspective exists in the speech of providers it is not expressed in the daily work since the services do not explicitly promote the empowerment of both girls and boys. The idea of sexual and reproductive rights as basic human rights is present in the providers' speech but it is not reflected on their daily activities. The services do not carry out educational actions that could make adolescents aware of their rights.

However, despite the difficulties and lack of resources described, both Adolescent Services studied are just an example of the innumerable actions that the medical and technical staff can carry out in order to provide quality health care to adolescents. It is

important to highlight some differences between both Adolescent Services regarding some theoretical conceptions and the strategies applied to put them in practice:

1. Holistic care: At the Rivadavia Hospital, health care is provided by a an interdisciplinary team composed by physicians, psychologists and education specialists, who share a common work space, which helps to practice, even if not completely, the idea of holistic health care. When necessary, patients are referred to other professionals in different services (e.g. Obstetrics Service, lab, etc.).

At the Argerich Hospital, the Adolescents Service staff includes physicians from different specializations: gynecologists, pediatricians, and general doctors. When referral is necessary, patients are sent to a professional sympathetic to adolescents in another service (e.g. Psychopathology Service, the Social Service, Obstetrics Service). From our perspective, the holistic approach is better implemented in case of the Rivadavia service.

2. Sexual education: As it was previously mentioned, at the Rivadavia Hospital the admissions interview is carried out jointly by a physician and a psychologist. The patient is given basic information on sexual education during the interview and later invited to attend the information group. Once she has attended the group the patient meets again with the psychologist for a "diagnostic interview" and if she wants, or if she needs to clarify any doubts about sexual education, she can ask for additional information. In the case of the Argerich Hospital, all information about sexuality is given by the physicians during the admissions interview and in the follow-up visits. They provide informational brochures and booklets.

3. Work space: In both services equipment and supplies are insufficient, but at the Argerich Hospital the working conditions are far better than at the Rivadavia Hospital. The facilities are in good condition and the consulting rooms are more spacious and better equipped, allowing greater privacy for the patients during the medical exam. In the case of the Rivadavia Hospital, the facilities are quite old and poorly maintained.

The waiting room, which is also the entrance through which the staff and the patients access the service, is uncomfortable and noisy. The consulting rooms are very small, divided by wooden panels that do not allow privacy during the medical examination. The space where the psychologists work is in a little better condition, but since it is located on the fourth floor of the building, it becomes hard to find for those adolescents who might want to drop in voluntarily without being referred by other hospital professionals.

4. Reasons for contacting the service: The Adolescent Services at each of the hospitals studied focus on different issues, and this becomes evident in the different strategies they implement. In the case of the Rivadavia Hospital, since it is a section of the General Gynecology Service which sees exclusively adolescents, it is centered around issues of reproductive health and sexuality. The Adolescents Service at the Argerich Hospital, offers a broader array of services besides gynecology, it receives patients from both sexes who arrive with different health problems such as seasonal illnesses.

5. Research, professional exchange and debate: At the Argerich Hospital issues regarding specific patients are informally discussed among the service professionals. Research studies are carried out by the service staff members, in some cases in collaboration with researchers from other institutions. At the Rivadavia Hospital, they hold staff meetings every Monday to discuss medical cases, exchange opinions, and carry out research. Selected cases are also presented for discussion at the meetings of the General Gynecology Service. Also, the group of physicians on one side, and the psychologists and sociologists on the other side, meet regularly to discuss different topics regarding their specializations, such as updates, research activities, participation in professional conferences, and literature reviews, among other topics. This space for professional discussion has been sustained throughout time, even at times when the number of patients and the demand for medical services rises. This attitude has to do with the idea that a space for professional discussion and exchange is necessary in order to improve the quality of health care.

6. Contraception: Both Adolescent Services give great importance to the need to provide information and contraceptive methods to adolescents. They provide hormonal contraceptives more than any other contraceptive for reasons that have been previously described. This affects the promotion of safe sex and dual protection.

The Adolescent Services at each of the hospitals studied have different points of view regarding the IUD. The Rivadavia Hospital does not offer the IUD except in very particualr cases. This criteria is based on several theories and research studies that consider the use of IUD highly risky in adolescent nulliparous women. Although the Argerich Hospital shares the same risk concept and the medical staff prefers to insert the IUD in adolescent if they have at least two children, they have a more relaxed criteria for IUD insertion. For example, in the case of adolescents who are not good candidates for hormonal or barrier methods, and who are seen as prone to getting pregnant, the medical staff agrees to insert the IUD even if they are adolescent and nulliparous, as long as there are no specific

contraindications. This difference in opinion between both Adolescent Services is related to the different ways in which they view and understand the research studies about pelvic inflamatory disease and its potential risk for infertility. None of the professionals interviewed at both Adolescent Services mentioned at any time the female condom nor emergency contraception.

6.3. Users' perceptions and suggestions

According to what has been explained in Chapter 5, users of the Adolescent Service at both hospitals showed an ambivalent relationship with the service. On one hand they are satisfied with the attention and health care received, but on the other hand they are unsatisfied with the conditions under which the medical exam is performed (poor quality of the facilities, lack of privacy). Some of the suggestions to improve quality of health care delivery made by the Adolescent Service users themselves include:

Infrastructure:

- Most adolescents interviewed would like more comfortable and pleasant facilities that could allow greater privacy during the medical visit.

Medical attention:

- A significant number of adolescents interviewed demanded more respectful treatment. This implies greater respect in the doctor-patient relationship taking into consideration the diversity of knowledge, information, and cultural references, among other issues.
- The majority of interviewees expressed their wish to see the same physician in all their visits so as to allow for a more personalized service. This demand becomes explicit in the need to generate relationships of greater trust and confidentiality.
- Uniformed criteria for medical treatment: (e.g. one patient had to resort to another hospital to have an HIV test done because her general doctor thought that her gynecologist was the one who had to issue the lab request and the gynecologist thought otherwise).

Administrative matters:

- The whole sample of users interviewed claimed for a better organized and more rational system in the assignment of appointments that could reduce the waiting time and avoid crowded waiting rooms.
- Comply with pre-established appointments (“turnos”)

- Extension of the attention hours to the full day. Yet, even in the case of a service that works all day long the patients tend overwhelmingly to attend the medical service in the morning.
- In the case of strikes and work stoppages (which have been quite common in the 1990´s, given the financial restrictions of the public budget) the patients with an assigned appointment should be forewarned so that they do not have to waste time and money going to the hospital.
- Reduction of the waiting time for laboratory analyses.

According to some health care providers interviewed, it would be possible to satisfy many of these demands by making some minor changes. Some other demands require the political will to acknowledge the right to health as a basic human right and, consequently, to implement the above mention changes (increased staffs, particularly in labs; opportunities for training and/or re-training, time and resources for community work, etc.).

6.4. Final recommendations

Giving sexual and reproductive rights the status of basic human rights in legislation and public policies would allow the issue of reproductive health to be approached from the view of adolescents as subjects entitled to specific rights. Thus we offer some suggestions that could allow the development of strategies that include as a basic condition the participation of adolescents who are the ones who better know their own needs.

1) Effective policies and programs that include adolescents' participation in their design and implementation and that are thought in response to their own interests.
2) Programs that include relationships between different areas: education, health, and employment so as to reach out to adolescents who do not voluntarily access the service.
3) To establish relationships between public hospitals, government organizations, NGOs, schools, recreational and sports organizations, etc, in order to develop strategies that give priority to prevention and adolescent sexual and reproductive health care.
4) Using the mass media to produce and disseminate information designed with adolescent input.
5) Introducing the gender and rights perspective in the health care professions curricula (physicians, psychologists, nurses, administration staff).

Finally, legislation open to considering adolescents as active subjects entitled to rights, together with programs focused on the specificity of their demand, and quality integral health care services would allow (together with the implementation of other activities in other social environments) the development of competent, autonomous, and aware adolescents/youth.

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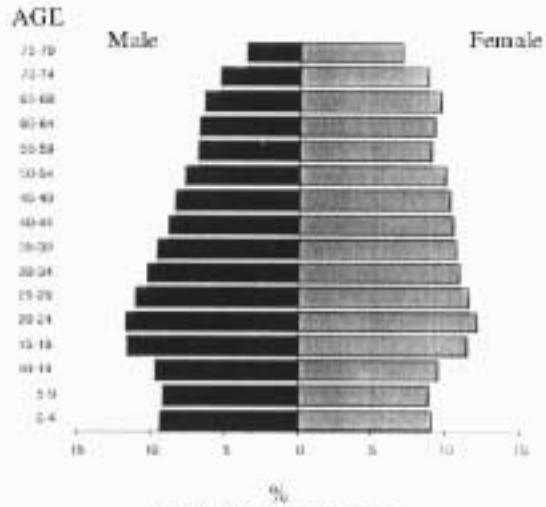
ANNEX 1

Table 1: Age and sex structure. City of Buenos Aires, 1997.

Age	Total	Male	Female
Total	3036891	1385940	1650951
0-4	183599	93335	90264
5-9	179070	91167	87903
10-14	191492	96595	94897
15-19	228533	114609	113924
20-24	237140	116498	120642
25-29	225321	109849	115472
30-34	210936	102193	108743
35-39	202111	95734	106377
40-44	192258	88035	104223
45-49	186167	83668	102499
50-54	175256	76644	98612
55-59	157201	68165	89036
60-64	157894	66912	90982
65-69	159570	64347	95223
70-74	139423	52851	86572
75-79	104303	35532	68771
80 and more	106617	29806	76811

Source:INDEC (Serie Análisis Demográfico 7) and Dirección General de Estadística y Censos.

Graph 1 Age and sex structure. City of Buenos Aires, 1997.



Source: Same as table 1

Table 2: Population per school assistance by age and sex groups, City of Buenos Aires. 1991

Age	Sex	3 years and older	Attends school	Does not attend but attended		Never attended	No answer
				Drop out students	Graduated		
10-14	*Male*	101.470	98.335	1.368	1.175	198	396
	Female	99.059	96.080	1.353	1.090	178	358
	Total	200.529	*194.415*	2.721	2.265	376	754
15-19	Male	103625	77618	11798	13579	262	368
	Female	109.644	82.856	10.535	15.544	285	424
	Total	213.269	160.474	22.333	29.123	547	792

Source: Data from 1991 Census (Tables P-4 and P-6). The table is our elaboration.

Table 3: Population of 15-19 years by sex and activity condition. Metropolitan Area. October 1998

Sex	Activity condition			Total
	Employed Population %	Unemployed Population %	Population out of the labor force %	
Male	23,0	9,5	67,5	100% (359.352)
Female	9,3	9,7	81,	100% (344.782)
Total	16,3	9,6	74,1	100% (704.134)

Source: Dirección General de Estadística y Censos, on the basis of EPH (Permanent Household Survey) data.

Table 4: Deaths (ICD 10) by sex for groups 10-14 and 15-19

Causes	Men		Women	
	10-14	15-19	10-14	15-19
I Some infectious and parasitic diseases	1	1	--	--
II Tumors	4	7	4	9
III Blood and immunological diseases	--	1	--	--
IV Metabolic, nutritional and endocrinological diseases	--	1	--	--
VI Nervous system diseases	3	2	1	3
IX Circulatory system diseases	2	5	2	5
X Respiratory diseases	1	8	3	5
XI Digestive system diseases	--	--	1	1
XVII Congenital malformations and chromosomal abnormalities	1	3	--	
XVIII Symptoms and signals not classified elsewhere	--	1	--	1
XX External causes of morbidity and mortality	10	43	7	10
TOTAL	22	72	18	34

N=146

Note: There were no cases in those categories not included in the table.
Source: data base provided by the Statistics Department of the City of Buenos Aires. The table is our elaboration.

Table 5: Suicide rates by age and sex. City of Buenos Aires. 1997

Age group	1997		
	Men	Women	Total
All	13.5	6.5	9.8
-15	--	--	--
15-19	1.7	3.5	2.6
20-24	10.3	5.8	8.0
25-29	14.6	6.1	10.2
30-34	12.7	6.4	9.5
35-39	16.7	8.5	12.4
40-44	15.9	10.6	13.0
45-49	16.7	7.8	11.8
50-54	19.6	11.2	14.8
55-59	24.9	9.0	15.9
60-64	17.9	11.0	13.9
65-69	24.9	9.5	15.7
70-74	15.1	2.3	7.2
75-79	42.2	8.7	20.1
80 and more	50.3	13.0	23.4

Source: Dirección General de Estadísticas y Censos (1998). Demografía Ciudad de Buenos Aires.

Table 6: Car accident mortality rates by age and sex.
City of Buenos Aires. 1997

Age group	1997		
	Men	Women	Total
All	9.1	3.1	5.9
-15	1.4	1.4	1.4
15-19	3.5	0.9	2.2
20-24	17.2	0.8	8.9
25-29	13.7	3.5	8.4
30-34	11.7	--	5.7
35-39	5.2	2.8	4.0
40-44	9.1	1.9	5.2
45-49	8.4	2.0	4.8
50-54	7.8	3.0	5.1
55-59	10.3	3.4	6.4
60-64	3.0	3.3	3.2
65-69	9.3	8.4	8.8
70-74	13.2	6.9	9.3
75-79	19.7	4.4	9.6
80 and more	53.7	11.7	23.4

Source: Dirección General de Estadísticas y Censos
(1998). Demografía Ciudad de Buenos Aires.

Table 7: AIDS mortality rates by age and sex. City of Buenos Aires. 1997

Age group	1997		
	Men	Women	Total
All	2.5	4.7	14.0
-15	5.0	1.5	3.2
15-19	0.9	--	0.4
20-24	12.0	9.1	10.5
25-29	66.5	26.8	46.2
30-34	88.1	9.2	47.4
35-39	61.6	6.6	32.7
40-44	47.7	6.7	25.5
45-49	20.3	2.0	10.2
50-54	11.7	4.1	7.4
55-59	20.5	--	8.9
60-64	6.0	1.1	3.2
65-69	12.4	--	5.0
70-74	--	--	--
75-79	2.8	1.5	1.9
80 and more	3.4	--	0.9

Source: Dirección General de Estadísticas y Censos
(1998). Demografía Ciudad de Buenos Aires.

Table 8: Public hospitals discharges (ICD 9). Groups 10-14 and 15-19 by sex. City of Buenos Aires. 1995

Causes	women		men	
	10-14	15-19	10-14	15-19
Infectious and parasitic diseases	104	77	119	117
Malignant tumors	126	98	171	94
Benignant tumors	57	108	81	52
Metabolic, nutritional and endocrinological diseases	101	121	102	81
Blood and immunological diseases	100	27	45	18
Mental diseases	59	169	57	179
Nervous system diseases	202	123	232	156
Circulatory system diseases	18	40	36	130
Respiratory system diseases	150	151	182	177
Digestive system diseases	254	370	349	258
Genitourinary system diseases	63	213	180	92
Complications of pregnancy, partum and puerperium	201	6090	----	----
Skin diseases	44	78	83	39
Bone and connective tissue diseases	193	151	150	122
Congenital abnormalities	112	88	319	161
Traumatisms and poisoning	275	275	551	473
Other reasons to contact health services	66	114	29	25
Unproperly defined	172	144	79	91
TOTAL	2297	8437	2765	2265

Source: Ministerio de Salud y Acción Social (1998). Programa Nacional de Estadísticas de Salud. Egresos de Establecimientos Oficiales por Diagnóstico, 1995. Serie 4. Número 18.

Table 9: Obstetric discharges. Groups 10-14 and 15-19. Buenos Aires. 1995

Obstetric discharges	10-14	15-19
Normal delivery	123	3804
Pregnancy ended in abortion	2	412
Direct causes	76	1832
Other complications	--	42
TOTAL	201	6090

Source: Ministerio de Salud y Acción Social (1998). Programa Nacional de Estadísticas de Salud. Egresos de Establecimientos Oficiales por Diagnóstico, 1995. Serie 4. Número 18.

Table 10: Traumatic causes of discharge by sex. Groups 10-14 and 15-19. Buenos Aires. 1995

Traumatic causes	women		men	
	10-14	15-19	10-14	15-19
Fractures	45	56	144	139
Burns	35	29	23	18
Poisoning	36	63	21	10
Other traumatisms	159	127	363	306
TOTAL	275	275	551	473

Source: Ministerio de Salud y Acción Social (1998). Programa Nacional de Estadísticas de Salud. Egresos de Establecimientos Oficiales por Diagnóstico, 1995. Serie 4. Número 18.

Table 11: Causes of maternal mortality. Cases and rates (per ten thousand live births). Buenos Aires. Years 1980-1997

Year	Live Births	Total Deaths	Causes		Rate
			Abortion	Other	
1980	44100	17	13	4	3.9
1981	43070	11	1	10	2.6
1982	41031	5	1	4	1.2
1983	41046	8	6	2	1.9
1984	39893	13	8	5	3.3
1985	44258	5	2	3	1.1
1986	44806	12	6	6	2.7
1987	43884	15	5	10	3.4
1988	43553	12	6	6	2.8
1989	42614	12	6	6	2.8
1990	41333	16	8	8	3.9
1991	40553	4	2	2	1.0
1992	38716	4	--	4	1.0
1993	38507	7	2	5	1.8
1994	39209	3	2	1	0.8
1995	40240	4	2	2	1.0
1996	39996	3	2	1	0.8
1997	39897	--	--	--	--

Source: Dirección General de Estadísticas y Censos (1998). Demografía Ciudad de Buenos Aires.

ANNEX 2

1. Description of the fieldwork

Strategies for selecting the programs and health care services

The research started with a bibliographical review and the identification, by means of various interviews with key informers, of the plans and programs available in the City of Buenos Aires concerning adolescent's sexual and reproductive health.

The first thing proved by the initial step of our research was the non-existence program of sexual and reproductive either at the City of Buenos Aires or the national level. Such programs, however, do exist in some provinces in the country.

In light of this situation we decided to carry out an analysis of the National Plan for the Integral Health of Adolescents. This plan comprises all the aspects and dimensions of adolescent health. Reproductive health occupies a minor part of the National Plan, but the fundamental principles regarding reproductive health and sexual education are contained in its pages.

On the other hand, there exists in the City of Buenos Aires the Program of Responsible Procreation (PPR) that hypothetically includes the teenagers. Despite the fact that the PPR was implemented in the majority of the city hospitals there are only two hospital's Adolescents Services that have access to it, one being the Argerich Hospital. The rest of the hospitals, the Rivadavia among them, participate in the PPR through other services, mostly the units of general gynecology.

In light of this reality, the research was oriented towards the people who participated in the elaboration of the National Plan. Accordingly, five officials or former officials involved with the National Plan at various stage were interviewed. Thanks to their reports and the information they provided it was possible to reconstruct the history of the Adolescents speciality in Argentina.

In addition, this information provided us with a better understanding of adolescent health care in Argentina as well. The offer is quite diverse: Adolescents Services coexist with Adolescents Groups and Adolescents Sections , and each one of these can be part of different hospital units, like General Clinic or Gynecology .

After the elaboration of an institutional map of services and units aimed at adolescent reproductive and sexual health it was decided, by the reasons explained in our report, that the research would concentrate in the Adolescents Service of the Argerich Hospital and the Adolescents Section of the Gynecology Service of the Rivadavia Hospital.

The field work started at the Argerich Hospital. In an initial meeting with two medical doctors of the Service the receptiveness to our task was warm and enthusiastic, and full cooperation with the research was promised. In an ensuing meeting the dynamics of work was established and the mechanism to carry out the interviews was agreed upon. The physical installations of the Hospital are nice and comfortable, and we were given an office to conduct the interviews with the selected individuals.

In order to process our request an official letter had to be sent to the Head of the Service explaining the reasons of our study. The field work took place in a cordial environment, and the multiple conversations we had with the members of the Service greatly enhanced our ability to understand how it works. Moreover, our insertion in the Service allowed us to observe the modalities of interaction between doctors and patients and the general organization and dynamics of the Service.

In the case of the Rivadavia Hospital, we had a first informal contact with the chairperson of the Psychology Area, to whom we explained the purposes of our research. She showed great interest in it and a second appointment was set, at which time the Head of the Adolescent Area and several doctors and psychologists of the team were also present.

We explained the nature of our research project. The strategy of the field work, the time schedules, and the place where we would carry out the interviews were defined. The interviews with the female users took place in the waiting room, a noisy and uncomfortable place that made our task cumbersome. The interviews with the members of the service were done in their offices.

CEDES research team offered a tuition fellowship to study research methodology to some member of the staff in its Master´s Program in Social Sciences and Health and also offered further advise to the Service in its research projects. This attitude was very well regarded by the members of the Service because they perceived a real interchange of information and knowledge was possible.

Observation and Field Diary

The fieldwork was started at the begining of June and was concluded by mid-August. The total number of interviews was 51: five to officials or former officials; 15 to the staff people of the services; and 31 to patients/users of the services (See Tables 12-14).

The fieldwork was carried out in the morning working hours. In the first stage the interviews with the users were made at random but, (a) trying to proportionally distribute

the age groups between ages 10 and 19; and (b) trying to include patients with a previous contact with the service t in order to make sure that they know the diverse aspects and facets of the Service.

We only experienced two refusals: in one case a 12 years-old girl whose mother decided negatively at our request, and the other an adolescent that declared not to have time. Two interviews were interrupted roughly when the patients were called by the doctor and when their visit to the doctor was over they did not want to continue allegedly because of lack of time. The users displayed an array of reactions, ranging from surprise to enthusiasm to apathy, responding very briefly. In the majority of the cases it was very difficult to obtain detailed responses to our questions.

Regarding the interviews with the staff, there was from the very beginning and in both hospitals, an excellent predisposition of their members to participate in the research. The appointment with the doctors and psychologists was made in their working hours. It was a long waiting time between one interview and other. That time, however, was used to observe the general functioning of the services, the activities carried out by its members, informally talk with the members of the staff adding a better understanding to the object of our research.

An informed consent was read each interviewee and in all cases it was accepted without objections. The providers interviews always started the interview with a question about its estimated duration, but later on the professionals extended by themselves the duration of the interview with the lengthy elaboration of their responses. Their arguments are key inputs for a general perspective not only of the health providers and patients but also of the daily life in an Adolescent Service.

The selection of two services whose staff shared a fundamental premise on the necessary holistic nature of the adolescent health care, and the passion found in the two services to overcome all the day to day difficulties made of our research a very significant personal and professional experience.

Table 12: Selected characteristics of public officials interviewed

SEX	**PROFESSION**	**POSITION**
Female	Physician - Obstetrician	Coordinator of the Obstetric Area of the Adolescent Service at the -University Hospital Gral.San Martín
Female	Physician -	Chair Public Health Department - National University of Tucumán
Female	Psychologist	Coordinator Psychology Area of the Adolescent Sector. Gynecology Service Rivadavia Hospital
Male	Physician - Pediatrician	Former Director of the Responsible Procreation Program
Male	Physician - Pediatrician	Director of the National Adolescent Plan at the Ministry of Health and Social Welfare

Table 13: Selected characteristics of providers interviewed

Argerich Hospital

Sex	Age	Profession	Has worked in the service for....	Training in adolescence
Female	24	Medical Student	2 months	NO
Male	33	Pediatrician	2 months	YES
Female	36	Psychologist	11 years	YES
Female	38	Gynecologist	11 years	YES
Female	42	Pediatrician	10 years	YES
Male	48	Pediatrician	10 years	YES
Female	66	Gynecologist	10 years	YES

Rivadavia Hospital

Sex	Age	Profession	Has worked in the service for....	Training in adolescence
Female	31	Psychologist	2 years	YES
Female	33	Gynecologist	1 year	YES
Female	34	Psychologist	6 months	YES
Female	44	Psychologist	9 years	YES
Male	45	Gynecologist	7 years	YES
Female	46	Gynecologist	17 years	YES
Female	46	Gynecologist	17 years	YES
Female	49	Gynecologist	10 years	YES
Female	56	Psychologist	5 years	YES

Table 14: Selected characteristics of users interviewed

Argerich Hospital

Sex	Age	Origin	School Level	Occupation	Reasons for consul
Female	11	Buenos Aires City	Attending primary	Student	Vaginal pain
Female	14	Grater Buenos Aires	Uncompleted primary		Pregnancy
Female	15	Buenos Aires City	Attending secondary	Student	Upset cycle
Female	16	Greater Buenos Aires	Uncompleted primary		Infections
Female	17	Greater Buenos Aires	Attending primary	Student with financial aid	Hair problems
Female	17	Paraguay	Attending secondary	Hairdresser	Contraception
Male	17	Buenos Aires City	Attending secondary		Allergies
Female	18	Buenos Aires City	Attending secondary	Telephonist	Breast cyst
Female	18	Buenos Aires City	Uncompleted secondary	Housekeeper	Pregnancy
Female	19	Buenos Aires City	Complete Vocational School	Optician	Check up
Female	19	Bahía Blanca	Uncompleted primary	Housekeeper	Doesn't refer
Male	19	Corrientes	Uncompleted primary	Construction worker	Clinical visit
Female	20	Corrientes	Attending secondary	Student	Clinical visit

Table 14 (continued)

Rivadavia Hospital

Sex	Age	Origin	School Level	Occupation	Reasons for consult
Female	15	Paraguay	Attending secondary	Student	Contraception
Female	16	Bolivia	Uncompleted primary	Dressmaker	Post curettage check up
Female	16	Greater Buenos Aires	Attending secondary	Student	Psychology
Female	17	Provincia de Buenos Aires	Attending secondary	Student	Gynecological check up
Female	18	Uruguay	Complete secondary	Employee in a design studio	Contraception
Female	18	Salta	Uncompleted secondary		Psychology
Female	18	Buenos Aires City	Attending vocational school	Student	Contraception
Female	18	San Juan	Uncompleted secondary		Fertility
Female	19	Provincia de Buenos Aires	Complete primary		Contraception
Female	19	Greater Buenos Aires	Complete secondary		Contraception
Female	19	Greater Buenos Aires	Complete secondary	Commercial Promotions	Upset cycle
Female	19	Buenos Aires City	Attending secondary	Student	Upset cycle
Female	20[25]	Bolivia	Doesn't refer		Contraception-Psychology
Female	20	Misiones	Uncompleted secondary		Lost pregnancy
Female	20	Paraguay	Uncompleted secondary		Pregnancy
Female	20	Paraguay	Uncompleted secondary	Maid	Pregnancy
Female	20	Perú	Uncompleted secondary	Hairdresser and maid	Upset cycle
Female	20	Buenos Aires City	Uncompleted secondary		Post pregnancy check up

[25] Even though we followed the WHO definition of adolescence which includes ages 10-19, at the Rivadavia Hospital, which admits patients up to 20 years of age, the majority of the patients were between 17 and 20, and in order to complete the fieldwork on time, six 20 year old girls were interviewed.

III. CASE STUDY

Adolescent Reproductive Health Programs in México, D.F., México

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El Colegio de México

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ACRONYMS

AA	*Alcohólicos Anónimos* (Alcoholics Anonymous)

AMGIJ	*Asociación Mexicana de Ginecología Infanto-Juvenil* (Mexican Association of Infant-Juvenile Gynecology)
AMSA	*Asociación Mexicana para la Salud de los Adolescentes*, Mexican Association for the Health of Adolescents)
CAA	*Clínica para la Atención del Adolescente* (Clinic for the Attention of Adolescents)
CAVI	*Centro de Atención a la Violencia Intrafamiliar* (Centre for the Attention of Intrafamiliy Violence)

CGPPFSEINP*Clínica de Ginecología Pediátrica, Planificación Familiar y Servicio de Endocrinología del Instituto Nacional de Pediatría* (Clinic for Pediatric Gynecology, Family Planning and Endocrinology of the National Institute of Pediatrics)

CIJ	*Centros de Integración Juvenil* (Youth Integration Centres)
CONADIC	*Consejo Nacional contra las Adicciones* (National Council Against Addictions)
CONASIDA	*Consejo Nacional para la Prevención y Control del SIDA* (National Council for the Prevention and Control of AIDS)
CORA	*Centro de Orientación para Adolescentes* (Orientation Centre for Adolescents)
CSSSADF	*Coordinación Sectorial de la Secretaría de Salud del Distrito Federal* (Sectoral Coordination of the Secretariat of Health of the Federal District)
DDF	*Departamento del Distrito Federal* (Department of the Federal District)
DF	*Distrito Federal* (Federal District)
DGPF	*Dirección General de Planificación Familiar* (General Directorate of Family Planning)
DGPS	*Dirección General de Promoción a la Salud* (General Directorate for Health Promotion)
DGSR	*Dirección General de Salud Reproductiva* (General Directorate for Reproductive Health)
DIA	*Programa de Desarrollo Integral del Adolescente* (Program for the Integral Development of Adolescents)
DIF	*Sistema Nacional para el Desarrollo Integral de la Familia* (National System for the Integral Development of the Family)

DSSPGDF	*Dirección de Servicios de Salud Pública del Gobierno del Distrito Federal* (Public Health Services Office of the Government of the Federal District)
GAAPP	*Grupo Académico de Apoyo a Programas de Población* (Academic Gruop for the Support of Population Programs)
GDF	*Gobierno del Distrito Federal* (Government of the Federal District)
GIRE	*Grupo de Información en Reproducción Elegida* (Elected Reproduction Information Group)
GISR	*Grupo Interinstitucional de Salud Reproductiva* (Interinstitutional Group for Reproductive Health)
HIM	*Hospital Infantil de México* (Children's Hospital)
HM	*Hospital de la Mujer* (Women's Hospital)
HMII	*Hospital Materno Infantil Inguarán* (Inguarán Children's and Maternity Hospital)
ICPD	International Conference on Population and Development
IES	*Institutos Estatales de Salud* (State Institutes for Health)
IMSS	*Instituto Mexicano del Seguro Social* (Mexican Institute of Social Security)
INEGI	*Instituto Nacional de Estadística, Geografía e Informática* (National Institute of Statistics, Geography and Informatics)
ISSFAM	*Instituto de Seguridad Social de las Fuerzas Armadas Mexicanas* (Institute of Social Security for the Mexican Armed Forces)
ISSSTE	*Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado* (Institute of Social Security and Social Services for State Employees)
MEXFAM	*Fundación Mexicana para la Planeación Familiar* (Mexican Foundation for Family Planning)
PEMEX	*Petróleos Mexicanos* (Mexican Petroleum)
PHANM	*Programa Hospital Amigo del Niño y de la Madre* (Friendly Hospital for Children and Mothers Program)

PNASRA	*Programa Nacional de Atención a la Salud Reproductiva de los Adolescentes* (National Program for the Attention of Adolescent Reproductive Health)
PNPAIMA	*Programa Nacional de Prevención y Atención Integral a Madres Adolescentes* (National Program for the Prevention and Comprehensive Care to Adolescents Mothers)
PRD	*Partido de la Revolución Democrática* (Party of the Democratic Revolution)
PREA	*Programa Educativo para Adolescentes* (Educational Program for Adolescents)
PRI	*Partido Revolucionario Institucional* (Party of the Institutional Revolution)
PSRPF	*Programa Nacional de Salud Reproductiva y Planificación Familiar* (National Reproductive Health and Family Planning Program)
SEP	*Secretaría de Educación Pública* (Secretariat of Public Education)
SIETS	*Servicios Integrales de Diagnóstico y Tratamiento de las Enfermedades de Transmisión Sexual* (Integral Services of Diagnosis and Treatment of Sexually Transmitted Diseases)
SNM	*Sanidad Naval y Militar* (Navy and Military Health)
SNS	*Sistema Nacional de Salud* (National Health System)
SSDF	***Servicios de Salud del Distrito Federal* (Federal District's Health Services)**
SSA	*Secretaría de Salud* (Secretariat of Health)

Chapter 1. Institutional context of adolescent health care

1.1 The health system in Mexico.

Mexico has a mixed health system formed by several public and social security providers and a large private sector. Access to some of these health care providers is restricted to specific sectors of the population, while resources and quality vary from one service to another.

After 1982, health care became a constitutional right aimed to provide all Mexicans, regardless of their income, with access to quality public health services. The *Sistema Nacional de Salud* (SNS, National Health System), was organized for this purpose.[26] Public health services are divided into two categories: those that provide services for the working population with a formal contract who, by law, have to belong to a social security system (and who are called social security beneficiaries) and those for the population that is not covered by this system (called open population or non-beneficiaries). Employees working in the formal sector receive health care from different social security institutions which provide additional benefits such as disability and old-age pensions, among others. Social security health care covers the employee and his/her dependent family. Among the most important social security institutions can be mentioned: the *Instituto Mexicano del Seguro Social* (IMSS, Mexican Institute of Social Security), the *Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado* (ISSSTE, Institute of Social Security and Social Services for State Employees), the services of *Sanidad Naval y Militar* (SNM, Navy and Military Health), the *Instituto de Seguridad Social de las Fuerzas Armadas Mexicanas* (ISSFAM, Institute of Social Security for the Mexican Armed Forces) and the Medical Services of *Petróleos Mexicanos* (PEMEX, Mexican Petroleum) (Gómez de León, 1995:32).

Among the most important institutions that provide services for the open population are: the *Secretaría de Salud* (SSA, Secretariat of Health), the *IMSS-Solidaridad* (IMSS-Solidarity) program, which covers poor rural communities, the *Sistema Nacional para el Desarrollo Integral de la Familia* (DIF, National System for the Integral Development of the Family), state health services, and also medical services provided by the then *Departamento del Distrito Federal* (DDF, Department of the Federal District), *Gobierno del Distrito Federal* (GDF,Government of the Federal District) as from December 1997. Approximately 40% of the population is covered by some sort of social security institution.

This population is mainly made up by formal urban workers, since social security coverage is limited in rural areas. Private services, on the other hand, are made up by independent physicians and private companies providing health care.

Services provided by the Secretariat of Health are organized in three levels of attention, according to their increasing level of complexity. The primary level of attention includes admittance into health services and activities centered on the individual, families and communities. Services are focused on preventive health, early detection, timely treatment and rehabilitation from common ailments. The secondary level provides specialized out-patient consultation services and hospitalization for patients who are channeled from the primary level, as well as for those with serious medical emergencies. Finally, the terciary level offers healing and rehabilitation services for patients who are channeled from the other two levels with highly complex illnesses that require specialized treatments.

Regarding health services decentralization, on August 20, 1996, the Health Secretary, along with all 31 governors and the head of the government of the Federal District, signed the agreement for the decentralization of health services with the purpose of having state governments take charge of these services for the open population (that which is not covered by any social security system). Programs were designed according to specific hygienic and health needs, which resulted in the creation of the *Institutos Estatales de Salud* (State Institutes of Health). In 1998, this process concluded when hopital institutions, material and human resources, and budgets were handled over to state governments and to the D.F (Becerril, 1999).

The descentralization of health services has introduced overall changes in the administration of health services. On the one hand, the decrease in decision-making at the central level and its transference to the state level has allowed to search for formulae to re-organize the administration of services more in agreement with local needs. On the other hand, it has incentivated a clearer definition of obligations at the local level, incorporating the municipalities (equivalent to counties in the U.S.) in the accomplishment of their responsibilities in terms of the health of their population.

1.2. Background with regard to adolescent reproductive health care.

[26] The SNS has the objective of bringing together the efforts of all institutions that provide health care under rational schemes of planning and coordination, harmonizing thereby the programs

Implementing the recommendations derived from the International Conference on Population and Development (ICPD) (Cairo, 1994) in Mexico was preceded by a set of actions, within the sexual and reproductive health scope, developed by some of the main health agencies of the country: the *Dirección General de Planificación Familiar* (DGPF, General Directorate of Family Planning) of the SSA, the DIF, the CONASIDA and the *Secretaría de Educación Pública* (SEP, Secretariat of Public Education), among others. In July 1994, federal elections were held and the change of administration implied making new policies and elaborating a six-year program which favored the inclusion of the agreements reached at Cairo. So reproductive health was introduced as a term and as a concept in development plans, in public policies and in institutional programs. The concept was incorporated into the most important normative plans of the public sector which had to do with reproductive health. The *Grupo Interinstitucional de Salud Reproductiva* (GISR, Inter-Institutional Group for Reproductive Health), created in February 1995, included the main public agencies and representatives from NGO's involved in the field, and was in charge of putting together the *Programa Nacional de Salud Reproductiva y Planificación Familiar 1995-2000* (PSRPF, National Reproductive Health and Family Planning Program 1995-2000). This program can be considered the programmatic response to the challenges of the ICPD, addressing the main problems of reproductive health. It has among its purposes to incorporate the gender perspective in every component, considering information, education and communication strategies as key factors. Once the concept of reproductive health was included in the most important public health programs, the next step was to create awareness and promote its assimilation among service providers and users. This assimilation of the concept and its approach have not been easy.

Likewise, in spite of the efforts and multiple activities undertaken, there are still challenges and problems to solve regarding the decentralization of health services and even more so within a framework of reduction of public resources destined for health.

Adolescent reproductive health services, in particular, started to receive explicit public attention in 1993, when the SSA established the *Programa Nacional de Atención a la Salud Reproductiva de los Adolescentes* (PNASRA, National Program for the Attention of Adolescent Reproductive Health) through what was then called the *Dirección General de Planificación Familiar* (DGPF, General Directorate for Family Planning). After 1995, the Direction was renamed the *Dirección General de Salud Reproductiva* (DGSR, General

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carried out by state governments and by the social and private sectors.

Directorate for Reproductive Health). A meeting with the main governmental and non-governmental organizations involved with the health of adolescents was convened in order to discuss the proposal for the Program. Each institution contributed its experience, attained through a long history of consolidated and recognized work. Out of this meeting the "Monterrey Declaration" (GAAPP, 1995) was born. This document established the bases for initiating the program, which started functioning in 1994 in five different states, and served to legitimate it.

It should be acknowledged, however, that several programs linked with adolescent health existed already in Mexico, among which the following are worth mentioning:[27]

The *Centro de Orientación para Adolescentes* (CORA, Orientation Centre for Adolescents) is a non-governmental pioneer organization in this field. Since 1978 it started developing several programs of holistic services for adolescents, and has set forth strategies and programs in several hospitals. The program *Gente Joven* (Young People) of the *Fundación Mexicana para la Planeación Familiar* (MEXFAM, Mexican Foundation for Family Planning), established in 1986, provides educational and community activities by training voluntary youth promoters and by offering medical and family planning services at health centres and medical offices distributed all over the country.

Among the governmental or semi-governmental programs the following can be mentioned: the IMSS, which for some years has also had prevention programs and services for the reproductive health of adolescents; the DIF, where the *Programa de Desarrollo Integral del Adolescente* (DIA, Program for the Integral Development of Adolescents), which functioned until 1997, and the *Programa Nacional de Prevención y Atención Integral a Madres Adolescentes* (PNPAIMA, National Program for the Prevention and Comprehensive Care to Adolescent Mothers), which continues working, were implemented. Finally, at the hospital level, services that have provided specialized attention to the adolescent population for a number of years can also be found. A pioneer institution, in this sense, is the Pilot Clinic of Sexual Orientation and Family Life for Adolescents at the *Hospital Infantil de México* (HIM, Children's Hospital). The *Clínica para la Atención del Adolescente* (CAA, Clinic for the Attention of Adolescents) at the *Hospital Materno Infantil Inguarán* (HMII, Inguarán Children's and Maternity Hospital), the *Hospital General Doctor Manuel Gea González,* which has integrated an educational and

[27] We do not mention several institutions that work with adolescents in preventive activities regarding sexual education and family planning but that do not include attention to the adolescent's physical health, as well as several actions aimed at the sexual and reproductive health of tenagers through the educational system and mass communications.

comprehensive care system for adolescent patients, and the *Clínica de Ginecología Pediátrica, Planificación Familiar y Servicio de Endocrinología del Instituto Nacional de Pediatría* (CGPPFSEINP, Clinic for Pediatric Gynecology, Family Planning and Endocrinology of the National Institute of Pediatrics), which provides preventive education and special attention to pregnant adolescents, are worth mentioning.[28]

However, it is only since 1995 that services for the reproductive health of the adolescent population have received foremost attention from the State. This issue was defined as one of the four pillars -along with perinatal health, family planning and women's health- on which the PSRPF was built.

1.3. Programs selected.

For this evaluation we selected two programs. At the primary level of attention, we selected the PNASRA, also called "*En Buen Plan*", of the Ministry of Health,[29] and at the secondary level of attention the *Programa Educativo para Adolescentes* (PREA, Educational Program for Adolescents) at the *Hospital de la Mujer* (HM, Women's Hospital).

1.3.1. Program "*En Buen Plan*".

The main objective of the "En Buen Plan" program is to protect and to foster the right of the adolescent population to have access to information, communication and reproductive health services, with a holistic approach that promotes responsible attitudes and behaviors, which in turn should allow adolescents to exercise their sexuality with awareness and in an autonomous, risk-free way.

The program started with the implementation of adolescent service modules providing medical, psychological and counselling services at SSA's health centres and hospitals. These services are provided by a multi-disciplinary group (a medical doctor, a psychologist, a nurse, and a social worker). In July 1994, four modules were implemented in the D.F. at some of the city's Health Jurisdictions; several more were started in other

[28] The emergence of specialized attention to the health of adolescents in Mexico in the 1970s was the result of the interest of pediatricians. It is only recently that gynecologists began to get involved in the sexual and reproductive health of adolescents. The organization of AMSA (*Asociación Mexicana para la Salud de los Adolescentes*, Mexican Association for the Health of Adolescents) in 1989, which it is an organization formed mainly by peditricians, and of the *Asociación Mexicana de Ginecología Infanto-Juvenil* (AMGIJ, Mexican Association of Infant-Juvenile Gynecology) almost ten years later, in 1998, reflect the gap in the interest of gynecologists in adolescent health.

[29] The formal name of the program is *Programa Nacional de Atención a la Salud Reproductiva de los Adolescentes*, but it has informally come to be known as "*En Buen Plan*" (which can be translated approximately as "to be cool"), which is a colloquial Mexican phrase that means that something is done with good intentions. In this case, the word "plan" is used as part of a play on words, since it is part of the word "planifica" (planning), which is the central message of the family planning campaigns that have been launched in the last few years through mass communications.

cities. The module program quickly caught on all over the country, and by 1999 there were 259 modules in Mexico distributed in 179 health centres and 80 hospitals.

Since 1997, as a consequence of the decentralization of health services started in 1995, the modules in the D.F. started being operated by the *Dirección de Servicios de Salud Pública del Gobierno del Distrito Federal* (DSSPGDF, Public Health Services Office of the Government of the Federal District). Up to now, 16 modules have been installed, one in each Health Jurisdiction, which in the case of the capital correspond to the political-administrative Delegations of the D.F. For our study, we selected the Iztapalapa Delegation Module.

At the end of 1997, the Secretariat of Health determined that services addressed to adolescents start a coordinated effort with the *Dirección General de Promoción a la Salud* (DGPS, General Directorate for Health Promotion), the *Consejo Nacional contra las Adicciones* (CONADIC, National Council Against Addictions) and the CONASIDA, with the purpose of having the services detect and prevent addictions and the propagation of AIDS among the young population (Beltrán Aguirre and Benet Jiménez, 1997:14).[30]

On the other hand, since September 1998, the Secretariat began restructuring the program, substituting the concept of module for the idea of specialized service, where medical attention for adolescents is provided at every SSA health unit in a "horizontal" manner, which means that only in one health centre of each Health Jurisdiction in the country, a module with staff specifically trained to provide holistic attention to adolescents will operate. This staff will, in turn, train the health personnel at every SSA unit so they can provide special treatment services for adolescents and in order for them to be able to channel adolescents, when deemed necessary, to the jurisdictional module where specialized counselling and other services are available. In this way, it is pretended that specialized services for treating adolescents will exist in all medical centres of the SSA in the country.[31]

"*En Buen Plan*" was the program's motto, and it slowly started identifying it and became its promotional slogan.

[30] In 1998, an evaluation of the PNSRA was carried out in ten selected states in the country, through interviews with the responsible officials in the state and jurisdictional levels, the service personnel and the adolescents themselves. Unfortunately, the results of this evaluation have not been made public and it has not been possible, to date, to get hold of them.

[31] This decision was made after a cost/benefit analysis of the module system was made, as part of the evaluation mentioned in footnote 12.

1.3.2. The *Programa Educativo para Adolescentes* (PREA) at the Women's Hospital.[32]

In 1988, CORA began a pilot work program along with the Women's Hospital. From this date on, a series of research programs were developed to answer to the needs of adolescent mothers that attended this hospital, which resulted in the implementation of PREA with the financial support of several international organizations. Between 1990 and 1991, an evaluation was carried out, in order to modify the program's strategy and increase its cost-effectiveness, for its transfer to the Women's Hospital and to other hospitals, so that it would operate independently of external support. In 1992, the post-natal component was institutionalized and the program started operating.

1.4. Analysis of the documents of the selected programs.

En Buen Plan is a program focused mainly on the prevention of unplanned and unwanted pregnancies, the prevention of STD's, including HIV/AIDS, and the prevention of addictions. The program's activities are based on the following strategies: a) education, where aspects of information, orientation and communication are included; b) medical attention at health centres aimed at pre-natal services, preventing unplanned pregnancies and counselling regarding sexual health and birth control; c) medical services in hospitals, focused on providing pre-natal care to the pregnant adolescent, providing attention during childbirth and to the new-born, as well as preventing new pregnancies; and, d) research and evaluation, supported on an information system generated by the modules as well as by research projects (Beltrán Aguirre and Benet Jiménez, 1997:13). The program works through service modules at the primary and secondary levels (health centres and hospitals). Its primary level functions are: comprehensive medical consultations, psychological consultations, reference to specialized medicine and obstetrics, orientation and counselling within the unit and outside, program promotion and coordination with institutions that provide support for adolescents.

The analysis of the program's documents revealed that a) the program is said to be justified on quantitative grounds: the adolescent population has doubled in the last few years, it represents a large proportion of the total population and, therefore, its attention is foremost in the reproductive health framework; b) there is a hierarchy in adolescent health problems which was determined to be: unplanned and unwanted pregnancies; STD's, including AIDS; and addictions, which find their causality in precocious sexual activity, lack

[32] The Women's Hospital is part of the *Coordinación Sectorial de la Secretaría de Salud del Distrito Federal* (CSSSADF, Sectoral Coordination of the Secretariat of Health of the D.F.) and it provides specialized care in gynecology and obstetrics.

of use of birth control methods as a consequence of spontaneity and lack of premeditation in sexual encounters, as well as the lack of sufficient information. This, in our opinion, makes adolescents look mostly like irresponsible and dependent subjects, uninformed and non-autonomous; c) though the program's central objective is to contribute to the reproductive health of adolescents, the concept of reproductive health is not defined within the programmatic document; d) similarly, the inclusion of the gender perspective enunciated is not explicit either; e) the program is focused on the prevention of unplanned pregnancies (through primary and secondary prevention and the postponement of the birth of the first child), without taking into account that many adolescent pregnancies are wanted; f) the target population is alternatively called "the adolescents" or "the young people" which implies that this group is considered to be homogenous, with common properties, and that, therefore, they have similar problems. However, when the places this population frequent are mentioned, a specific kind of adolescent emerges: one that goes to educational institutions, to gyms and to "disco's." This characterizes a stereotypically urban target-population that belongs more to middle than to lower class sectors; g) in the same way, this group appears as a passive entity, as a recipient of actions. When the adolescents appear as agents, regarding the exercise of their sexuality, it is in function of the need of a change in behaviors, product of the program's actions.

Moving now to the PREA, its main objective is to provide the open adolescent population of both sexes with multi-disciplinary attention in aspects linked with their reproductive health and with maternal-infant counselling. Adolescents are supplied with information and services so as to create an awareness of the benefits involved in adequately planning the number of children the couple wants to have and the importance of child spacing.

The program's documents point out: a) the biopsychosocial nature of the problems of adolescents, b) the objectives of the program, which are focused on educational aspects and on secondary prevention, mainly with regard to reproductive health, though holistic health attention to the open population that requires it is also mentioned, c) there is no explicit definition of what is understood as reproductive health, d) regarding the target population, it is referred to as "adolescent population" open to both sexes, but when the objectives of the program and the educational activities are mentioned, they are restricted to pregnant adolescents or adolescent mothers, e) adolescents are seen as individuals facing biopsychosocial problems and lacking information, f) there is no mention of the sexual and reproductive rights of adolescents, g) a gender perspective is not included, h)

strengthening self-esteem in adolescents through the construction of life goals is an important issue.

1.5. Obstacles and facilitators in the formulation and implementation of the programs.

We consider that a set of factors facilitated and a set of factors created obstacles to the formulation of the *En Buen Plan* program as well as the implementation of PREA. On the one hand, the Mexican State has provided foremost attention to planned parenthood programs since the mid-1970s. Although these were primarily oriented to couples, pressure and support from international organizations made the inclusion of reproductive health services aimed at the adolescent population easy. On the other hand, changes in the country's administration every six years (which implies a massive change of government officials), the pressures of the Catholic Church against birth control and sexual education outside the family, the vertical way health services work, and the huge amounts of red tape in Mexican institutions constitute the main obstacles to start and to operate this program.

At PREA, facilitating factors included acknowledgement by hospital authorities of the fact that a high percentage of their population constituted adolescents and the recognition that it was vital to provide them with special attention. However, some problems arose when the program was institutionalized, since the hospital's staff did not recognize this service as part of those provided by the institution, and the personnel were seen as outsiders. Similarly, hospital authorities gave the PREA staff activities that were not included in the program and, furthermore, it was unclear what institution this program belonged to. In addition, the hospital did not have a budget for the program at that moment. Currently, PREA has turned into one of the twenty-eight activities that the *Programa Hospital Amigo del Niño y de la Madre* (PHANM, Friendly Hospital for Children and Mothers Program)[33] carries out and therefore its actions are included in a set of strategies that emphasize breast feeding.

1.6. The influence of the Cairo Conference.

In the case of the *En Buen Plan* Program, both the documents analyzed and the information gathered through interviews suggest that the Programme of Action of the Cairo Conference and the Monterrey Declaration were greatly beneficial in the timing and planning of the Program. Both documents grant sexual and reproductive health a

[33] This program, established in 1991 by the SSA, includes hospitals which comply with a number of actions aimed at integrating maternal and child health services with an empshasis on the promotion of exclusive breast feeding.

fundamental importance within the rights of adolescents. For the current Assistant Director of the Program:

> "*Cairo reinforced the Monterrey Declaration, it consolidated the work we were doing, then we gave it support... Mexico had had progress in this work and ... the Cairo Conference consolidated what we had been doing. At the governmental level, Mexico was starting with its first steps to tackle the problem of adolescents directly... Mexico started breaking barriers, in 1994 we modified the technical norm of the family planning service in order to give adolescents easy access to birth control methods by medical prescription*[34]*; Cairo strengthened this and an avalanche of interest in the work with adolescents resulted.*"

In the case of PREA, the Cairo recommendations did not have any influence in its main objectives and strategies. Furthermore, a certain lack of information was perceived, both from the authorities and from the providers, regarding the information generated at this conference.[35]

1.7. Service selection criteria.

The selection of the *Módulo de Atención Integral al Adolescente in Iztapalapa* was decided after visits to several modules, which allowed the research team to see them working. From this preliminary contact, as well as from information gathered from interviews with officials from the Secretariat of Health and from the *Servicios de Salud del D.F.* (SSDF, Federal District's Health Services), we decided to choose this module, as it was one of the few that were still working properly after the decentralization of services in 1998. In addition, the fact that it was one of the four initial modules where the program got started and that both the nurse and the psychologist have been working there since the beginning, were elements that we considered adequate in order to appreciate certain continuity in service provision.

The selection of PREA was based on the fact that, among the existing specialized health services for adolescents at hospitals in the D.F. it is among the ones that has had greatest permanence. Another factor taken into account was the fact that it was a recognized NGO specialized in adolescent helath care (CORA) which had established the

[34] This norm, which rules both public and private services, did not make explicit reference, before 1994, to the right of adolescents to demand and receive contraceptive methods. The modification of the norm specifically includes this aspect. Although giving or prescribing contraceptive methods to adolescentes was not prohibited before the modification of the norm, the lack of legal prescripcions on the subject inhibited many physicians, who feared legal demands or sanctions for such a practice, to prescribe contraceptive methods to adolescents,.

[35] In Mexico, idelogical debate regarding women´s rights, reproductive rights, sexual rights, etc., often does not trascend (or has not yet trascended) to everyday practitioners in the health services.

model for service provision and trained the personnel originally working at the Women´s Hospital, with the idea of extending the model to other hospitals.

In the case of PREA, the selection of the service was based on the fact that the Women's Hospital is the only one in the D.F. that is part of the Secretariat of Health, which currently provides services aimed at the adolescent population.

Chapter 2. Characteristics of services.

2.1. *"En Buen Plan".*

2.1.1. Institutional structure, infrastructure, services provided and personnel.

This module is functioning at the T-III-A Health Centre[36] "Dr. Rafael Carrillo", which is part of the Federal District's Health Services and belongs to Iztapalapa's Health Jurisdiction. Currently, it is the only module specialized in attention to adolescents within this Jurisdiction.

The Module is open Monday through Friday from 9:00 a.m. to 2:00 p.m. The personnel that works there starts working at 8:00 a.m. and they leave at 3:30 p.m. A sign indicates that the Module is inside the health centre building. The Module has four consulting rooms, one for each professional. Though these spaces are small, they have audio and visual privacy, are clean and have good lighting. Among the services offered at this Module one can find family planning; emergency contraception (though not as a common practice); sexual education; pre-and post-natal care; detection and counselling on HIV/AIDS; counselling, detection and treatment of other STD's[37]; detection of cervical and uterine cancer; addictions; violence; psychological attention, and screening tests for congenital hypothyroidism and other metabolic conditions such as phenylketonuria and galactosemia. Adolescents who need vaccines are sent to the Health Centre's immunization services.

The health team working at the Module include a medical doctor (general physician), who coordinates the Module, a psychologist, a nurse and a social worker. The general physician (a female), has been working for this service for three years and is devoted to it full time (40 hours a week). The nurse works part-time (19 hours a week); the

[36] T-III-A implies that the health centre is ntegrated by ten MD's, ten nurses, ten social workers, an odontologist, a clinical lab, X-rays and a Department of Mental Health.

[37] When dealing with counselling, diagnosing and treating STD's and HIV/AIDS, the Module sends the patient to the *Servicios Integrales de Diagnóstico y Tratamiento de las Enfermedades de Transmisión Sexual* (SIETS, Integral Services of Diagnosis and Treatment of Sexually Transmitted Diseases) that operates in the same Health Centre. In these cases, the Module and the SIETS work in coordination.

rest of her time she works as the assistant of a doctor at the Health Centre, she is a nursing technician and has been working at the Module for five years. The social worker dedicates full time to her activities at the service and has been working there for three years. The psychologist works 35 hours a week and has been working for five years at the Module.

The Module develops and imparts two courses/workshops a year. One is aimed at pregnant young women and the other at adolescents of both sexes. The courses last one week. Aside from the health personnel who work at the Module, other professionals from the Health Centre are asked to participate as lecturers. This year, for the first time, the Module offered a course in sexual education to the teaching staff of a secondary school education program through television called *telesecundaria*. Through bulletin boards, subjects such as contraceptive methods, sexual education, pre-and post-natal care and breast feeding are presented. There are posters about HIV/AIDS and other sexually transmitted diseases. The service has brochures on family planning, sexuality, pre-and post-natal care, breast feeding, HIV/AIDS and other STD's, addictions, and gender issues. However, during our fieldwork, we did not see this material being offered to those using the service.

The Module keeps a file card on every prenatal care and family planning user. Besides, all clients who receive medical and psychological attention have a file with their clinical history and an appointment card where a record of their appointments is kept. The daily activities of each of the professionals working at the module are registered separately and a summary of these activities is sent each month to the Jurisdictional Coordination, which in turn sends it to the Federal District's Public Health General Coordination.

In the last six months, the Module has received three supervisory visits from the Federal District's Medical Service Reproductive Health Office. During our fieldwork, we had the chance to witness this event, which had as its main objective verifying that the distribution of the Woman's Card[38] by service providers to all women clients is being made. The visit, as well as the comments and suggestions from the supervising personnel are recorded in a book at the Module.

2.1.2 Functioning of the health team.

The permanence of the personnel working at the Module is a great advantage, while the non-exclusivity of the nurse is an obstacle for the service's dynamics. Each staff member

[38] A control card including: family and personal information; vaccines, pap smear and breast control information; family planning and perinatal health.

has received one or two training seminars aimed at adolescent care. These courses are highly valued. The personnel receives a salary, but they do not receive any special compensation for working with adolescents. The doctor has the obligation of seeing no more than twelve patients per day, which has caused her problems with the rest of the doctors in the Centre, who have to see somewhere between twenty and twenty-five patients a day. The doctor's position is that attention to adolescents requires more time in order to provide quality holistic care.

All the staff considered that the participation in seminars and courses regularly was indispensable. However, they mentioned they were not aware of the institutions that offered this kind of training and that the Health Centre put limitations on them regarding attending these programs. We were told that the new jurisdictional director had banned the Module's personnel from participating in the *Grupo de Información en Reproducción Elegida* (GIRE, Elected Reproduction Information Group) Network meetings. In order to justify his position he stated that the service could not afford to stop providing care during the network meetings. According to the providers at the Module, the lack of human, physical and material resources was another significant obstacle for them to carry out their activities. On several occasions, they have requested from Health Centre authorities a larger consultation room designed to carry out educational activities, to store didactic material and to do all their photocopying.

2.1.3. Laboratories, prescription drugs and birth control methods.

The laboratory at the Health Centre where the Module is found offers tests for detection of pregnancy, HIV and STD's (syphilis, gonorrhea, chlamydia, candida), and cervical cancer.

The Module provides adolescents with the following birth control methods: oral and injectable hormones, IUD's and condoms. However, the staff told us that sometimes they are out of some of the methods, especially condoms, since they do not receive them regularly from the responsible authorities.[39] The pharmaceutical industries do not provide them with any methods, but they offer support through donating material and snacks when the Module holds courses/workshops.

2.1.4. Flows, consultations and cost of services.

When the adolescent arrives at the Health Centre, he/she must go to the admission window. A secretary there will ask him/her what the reason for their visit is and his/her age.

[39] The Assistant Director of PNASRA claims that this is due to administrative problems. According to him, the government has instituted stricter measures for the supervision of the flow of condoms from the central agencies to the health centres and hospitals, and the administrative personnell at the health-centres are sometimes reluctant to follow the necessary procedures, which delays the distribution process.

If the adolescent is between the ages of 10 and 19, and after paying for the appointment, he/she is sent to the Adolescent Comprehensive Attention Module that is located on the first floor. Once at the Module, the nurse receives the adolescents. They are measured, weighed and their blood pressure is determined. The nurse also asks about the reason for the consultation and she opens their file, giving the information to the doctor or the psychologist so they are seen in the order they arrive at the Module. Other adolescents arrive with a prior appointment, when they are returning patients. If the adolescent needs information and orientation regarding birth control methods, the nurse provides the counseling.

If on that same day the adolescent or the couple wishes to adopt the method, they go in to see the doctor, who is responsible for prescribing it. However, it should be mentioned that not every adolescent that arrives at the Health Centre is referred to the Module. Pregnant adolescents or those that need information and orientation regarding birth control methods are given preference. The rest of the adolescents are sent to other doctors at the Centre.

Statistics from the Module indicate that, between June 1998 and May 1999, 3,542 medical consultations were given, of which 1,215 (34%) correspond to males and 2,327 (66%) to females. Of these 3,542 consultations: 987 were psychological consultations, 826 were of medical orientation and counselling, 485 of prenatal care and 113 for delivering contraceptive methods; the rest were devoted to social work and family planning counselling. In terms of contraception, 18 received and IUD, 16 oral hormones, 23 injectables and 56 condoms. Each user who asks for condoms is given 12 every time (not more than once a month), which is obviously insufficient.

The main reasons for attendance are pre-natal monitoring, birth control, respiratory, dermatological and orthopedic problems. In the area of psychology, the most common reasons for consultation are behavioral problems and learning disabilities. The psychologist sees five or six patients a day. Appointments, both medical and psychological, last approximately 45 minutes.

The services that have a cost (expressed in U.S. dollars) are: medical consultation ($0.65), psychological consultation ($1.40), Pap smear test ($0.65) and vaccinations ($0.65). The supply of birth control methods, the information, orientation and counselling regarding family planning, sexual education, HIV/AIDS and other STD’s have no charge.

Emergency contraceptives, dual method use, involvement of males in the decisions linked with sexuality and reproduction, the promotion of gender equality, self-esteem

issues, and pediatric attention to children of adolescent mothers are aspects not included in the Module.[40]

2.1.5. Characteristics of the population using the service.

Most adolescents that attend the Module live in the Iztapalapa Delegation and belong to the middle-lower and lower socioeconomic sector. Many patients who arrive pregnant are no longer attending school, either because they had dropped out previously for lack of interest or economic problems or because of the pregnancy itself. On average, their education level is no higher than the first or second year of secondary school. Male adolescents that attend for psychological consultations, however, are still in the educational system, and sometimes are sent to the service by the schools or educational institutions themselves.

The morning schedule and the fact that the Module opens only on weekdays is surely a limitation, for most adolescents that go to school do so from Monday to Friday during the mornings, so they cannot use the Module unless they skip school.[41]

The providers mentioned changes in the demands of adolescents. Nowadays providers are noticing an increasing number of young people who arrive at the Module looking for information on birth control methods, as well as adolescents who return after giving birth in order to adopt a birth control method. In a similar way, the health personnel are reporting an increase in young females with addiction problems and a decrease in the age these substances start being used.

2.1.6. Relationship with the community.

The health personnel noted that the establishment of activities involving the community has resulted from a slow but persistent job that initially involved "letting people know about them." Staff have focused their energies on this outreach activity, periodically visiting educational institutions in the area as well as health institutions where adolescents with drug addiction or violence problems are channeled. From the perspective of these providers, community work also includes visiting the outpatients that do not attend their scheduled consultations with the purpose of re-enlisting them in the Module. Lack of time, due to the great demand, is considered a big obstacle to carrying out community activities. The real link with the community consists in the channeling of their patients into other

[40] The fact that condoms are promoted and distributed does not necessarily mean that dual method use is being promoted, since the latter would imply promoting the use of condoms together with other methods designed to prevent pregnancy, which does not appear to be the case at the Module.

[41] In Mexico "morning" extends up to 2 p.m. The morning schedule in schools is normaly from 7:30 or 8:00 a.m. to 2:00 or 2:30 p.m.

institutions, such as the *Centros de Integración Juvenil* (CIJ, Centres for Juvenile Integration) and the *Centros de Atención a la Violencia Intrafamiliar* (CAVI, Centres for the Attention of Intrafamily Violence), the lectures on sexual education aimed at teachers and students in schools, and the stands they set up at health fairs in which they give out brochures promoting the Module. Other kinds of preventive actions are not carried out with the young people nor do they have links with religious institutions or other non-government organizations working with this sector of the population.

2.2. *Programa Educativo para Adolescentes* (PREA).

2.2.1. Institutional structure, infrastructure and services provided personnel.

The PREA is located at the Women's Hospital (which is part of the SSA). It is open Mondays through Fridays from 8 a.m. to 3:30 p.m. There is a sign with the program's name on the doors of each of the consulting rooms designated for this service. In one of these rooms, information and orientation is given regarding the services they provide and it is the place where the group sessions are held. This room is not appropriate for this purpose, given its reduced size and the constant noise. The other consultation room is used for the medical and psychological appointments and is not exclusively used by PREA. The program provides the following health services: family planning; sexual education; pre- and post-natal education; information, education and orientation on HIV/AIDS; HIV/AIDS tests; information, education, communication, diagnosis and treatment of STD's; detection of addictions; detection and treatment of violence issues; detection of cervical and uterine cancer; growth and development monitoring in children; information and education on breast feeding; psychological attention; and information, education and communication regarding self-esteem. The hospital, on the other hand, offers the services for normal childbirth and C-sections as well as treatment for incomplete abortions. The hospital has an immunization service where the PREA sends adolescents who need vaccines.

The health team that gives treatment to adolescents is made up of a general physician, two nurses (one of them is the program coordinator), a psychologist, a social worker and a secretary. With the exception of the doctor, who sees patients two hours a day, three times a week, the rest of the personnel is there full time (40 hours).

The program has brochures which are given to the adolescents who arrive at the service for the first time looking for information and orientation, and to those who attend the pre- and post-natal lectures. Posters on birth control methods, the feminine and masculine reproductive organs, breast feeding and feeding in the first months of life, are

found inside the consulting room where the lectures aimed at pregnant adolescents (PREA-natal) and adolescents who just became mothers or who underwent an abortion (PREA post-natal) are held. An average of fifteen adolescents attend each of these group sessions, which last for one hour and are offered by the health team. The subjects included in these sessions are family planning, breast feeding, new-born care, vaccines, enhancing early child development, weaning, feeding, decision making with regard to sexual and reproductive issues, sexuality, sexual organs, sexually transmitted diseases, family violence and addictions. While PREA-natal includes five sessions, PREA post-natal comprises four sessions. Besides, there are daily sessions on family planning and breast feeding in the area where adolescents who have undergone any obstetric event are hospitalized.

Daily activities are recorded in separate reports and every month a complete report of the actions that were carried out in the hospital area and in external consultations is compiled. It is then sent to the Coordinator of the *Hospital Amigo* Program. Both the nurse and the social worker send a monthly report of their activities to their respective coordinators. Personal information of all adolescents who are hospitalized is recorded in a separate book. Supervision is internal and is carried out by the PREA coordinator. PREA does not receive supervision from any other organization.

2.2.2. Functioning of the health team.

Staff in the PREA consider the annual rotation of the nursing staff and of the social workers, which is a hospital policy, as well as the part time schedule of the doctor as central problems. Obstacles deriving from difficulties of working with the doctor were also mentioned. From our point of view, the problem in this case resides in the doctor's lack of special sensitivity in working with adolescents. The coordinator and the psychologist from PREA received training to work with adolescents (they have three and five years at the Module respectively), while the nurse and the social worker, who recently started working at this program (two and seven months respectively) received guidance and instruction from the other two professionals regarding the content of the lectures and the "way of speaking to adolescents." Staff also mentioned the lack of appreciation and incentives on the part of hospital authorities regarding PREA's work.

The presence of a full time doctor is considered a priority for the PREA. We were told that the corresponding request, which has been presented several times by the program's staff, would be granted on the condition that the program showed productivity in every action it performs. This implies a quantitative increase of each of their activities, but

particularly in the adoption of a birth control method after giving birth. The presence of PREA during weekends and holidays is also considered necessary, especially in the hospitalization area. Furthermore, there is a need for a nutritionist and a pediatrician who can care for the most frequent problems in new-borns who are brought to the program for growth monitoring and, in terms of physical resources, there is a need for a larger space where PREA can hold its lectures.

Some notable gaps in the services rendered by the PREA are: emergency contraception, dual method use, male involvement, promotion, and primary prevention of pregnancy and/or STD's.

2.2.3. Laboratories, prescription drugs and birth control methods.

The hospital's laboratory offers the following tests: detection of pregnancy, of STD's, HIV/AIDS and cervical and uterine cancer. There was no mention of insufficiencies in this regard.

PREA promotes the adoption of the IUD and the condom and considers them the only methods that do not interfere with breast feeding. The staff told us that sometimes there has been no supply of pills and condoms. Some pharmaceutical industries provide them with oral and injectable hormonal contraceptives and a company that makes dairy products provides them with baby cereal and food supplements for pregnant adolescents.

2.2.4. Flows, consultations and cost of services.

Adolescents arrive at PREA in one of two ways: through external consultation or hospitalization. In the first case, pregnant adolescents arriving at the Hospital are registered when they have some problem or when they are close to giving birth and arrive at the Hospital to see if they can be admitted. The other (more common) way is when they are hospitalized for childbirth. They receive a lecture on birth control methods and breast feeding, are told about the services PREA offers and are invited to the post-natal lectures.

In the last six months, through external consultation 66 adolescents were referred to PREA. The main reasons for consultation were: providing birth control methods, IUD check ups, and follow-ups of other methods. In the psychology area, 180 adolescents received attention. Through hospitalization 1,352 adolescents were registered, of which 736 adopted an IUD, 412 condoms and 29 opted for tubal ligation. Seven hundred and twenty-eight adolescents had normal childbirths, 466 had C-sections[42], in 35 cases forceps

[42] A proportion much higher than is probably medically necessary and which might indicate a lack of quality control over doctors' decisions.

had to be used, 102 were curettages, one case was a trophoblast, 18 presented endometriosis and 5 an ovarian tumor. Twenty-nine patients had STD's and 11 cases were rape victims. There were sixteen stillbirths.

A medical consultation lasts for approximately 40 minutes, while a psychological consultation lasts for 45 minutes. The lectures for outpatients last for two hours while the ones given to hospitalized adolescents last for one hour.

The card for medical consultation has a cost (in U.S. dollars) of $2.65. The cost of childbirth or C-sections varies according to the socioeconomic level of the patient. Most of the patients are in levels 3 and 4 (lower and middle socioeconomic levels, respectively). A level 3 childbirth has a cost of $38 and a level 4 of $70; in the case of a C-section, the level 3 price is of $61 and the level 4 price is of $111. Each day of hospitalization in the case of normal childbirth costs $2.55 and in the case of a C-section $4.60. The lectures and the psychological consultations are free of charge.

2.2.5. Characteristics of the population using the service.

Patients are mostly pregnant adolescents and those who have already given birth at the Hospital. They belong to a middle-lower socioeconomic level but there are also cases of extreme poverty. In most cases, their activities are related to housekeeping. Most of them have not completed high-school and they live out of wedlock in their parents' or their in-laws' house. Males are excluded from PREA's services. Changes in the patient population pointed out by the providers include an increase in middle-class patients and patients with greater birth intervals.

2.2.6. Relationship with the community.

The health personnel identifies community work with their channeling patients to other government or non-government medical institutions. They do not perform any other community work since this is not considered to be a function of a secondary level health institution.

Chapter 3. Socioeconomic, demographic and epidemiological context of the adolescent population in the *Distrito Federal* (D.F., Federal District).

3.1. General situation: population, inequality and poverty.

In 1995, the D.F., capital of the country, had 8.5 million inhabitants plus approximately another 10 million that live in the city's metropolitan area. The group between ages 10 and 14 represents 9.2% of the population and the group between ages 15 and 19 represent 10%. The sex ratio of young people ages 15 to 19 was of 93.8 males to every 100 females in 1995 (CONAPO, 1996).

The situation in the D.F., as compared with the general situation in the rest of the country, is privileged both in its socioeconomic and educational levels as in the health and schooling conditions of its population. However, there are important deficiencies that affect the adolescent population as well as several risks that tend to increase for this age group.

Available statistics hide the high indices of inequality and poverty that prevail in the country's capital which, moreover, have been on the rise for some years now. The fact that in 1996, almost half the employed population with an income of some sort earned less than two minimum wages[43] (approximately US$130 a month), is a clear indicator (*Gobierno del Distrito Federal*, 1999:16). Adolescents and young people living in conditions of high and very high poverty in the D.F. represent more than 15% of the total population (Ibid.: 61).

3.2. Schooling, economic activity and unemployment.

In terms of educational level, for young people between the ages 15 and 24, 5% did not finish elementary school[44], 11.8% only finished elementary school, and 81.6% continued to study beyond the elementary level.

However, in spite of the continuous improvement in education levels, four out of every ten adolescents between the ages of 15 and 19 do not attend school, and more than one-third of this group does not work either (Ibid.: 21). The open unemployment[45] rate for this age group is 15.6% (Ibid.: 19).

In the D.F., 2.8% of the population between the ages 12 and 14 said they were economically active and the same was reported by 19.4% of the 15-19 age group. Comparing information from the D.F. with national data, it was observed, for the studied age groups, that the proportion of economically active population was much lower in Mexico City than in the rest of the country (Table 1.1).[46] Data obtained by the *Instituto Nacional de Estadística, Geografía e Informática* (INEGI, National Institute of Statistics, Geography and Informatics) suggest that in 1990 the kind of activity most frequently reported by the country's adolescent population was clerk or manual worker for both age groups (35.3% for the 12-14 age group and 59.8% for the 15-19 age group). It is important

[43] The minimum wage has lost almost 70% of its purchasing power over the last 16 years, and has therefore also lost its original meaning as a standard for measuring the income needed to sustain an average family of five members above the poverty line. More than five minimum salaries are nowadays needed for that purpose.

[44] School levels in Mexico are: elementary (6-12 year olds), secondary or lower middle level (13-15), preparatory or upper middle level (16-18) and university or superior level (19+).

[45] Open unemployment is defined as the population looking for a job who worked less than one hour during the week previous to the census or survey.

[46] Tables and charts can be found in Appendix 2.

to point out that a significant portion of both groups was employed in family jobs without receiving any pay (13.7% and 5.7%, respectively). Close to one fourth of the males in both groups were employed as day-workers or hired hands, and 20.5% of the first group and 16.1% of the second were self-employed. For women, working as clerks or manual workers was one of the main activities for both age groups (Table 1.2).

According to data from the *XI Censo General de Población y Vivienda* (11th General Population and Household Census), in 1990 38.9% of adolescents between the ages of 12 and 14 received less than one minimum wage per month and 45% of the population between the ages of 15 and 19 received from 1 to 2 minimum wages. In both groups, very few adolescents reported earning more than 3 minimum wages. This was more evident in the younger group. In both age groups, for every female that did not receive any income there were approximately four males in the same situation. In the other categories a similar proportion was observed between both sexes, except for the category of less than one minimum wage where the percentage of women was greater than the one of men (Table 1.3).

3.3. Sexuality, nuptiality, fertility, contraception.

The average age for a woman's first union in the D.F. (24.6 years of age for the generation born between 1967 and 1971) has risen (CONAPO, 1996:4) and adolescent fertility has decreased significantly.[47] However, births to women under age 20 still represent a high proportion (13.5%) of the total and the magnitude of the figure (23,000 a year) concerns health authorities (CONAPO, 1996:3), even though many of these women have a stable partner or are married.

Countrywide, in 1990 the number of women between 12 and 14 years of age with children was 12,720. This represented 0.04% of the total female population in this age group. In the 15-19 age group, the number of women with children was 511,642, which represented 10.43% of the total (INEGI, 1993a).

Countrywide, the percentage of women who had their first sexual experience at an early age (before 16) was reduced from 20.2% in the cohort born 1940-1949 to 10.9% in the cohort 1965-1969. However, in rural areas the fraction of women who had their first sexual experience before they were 16 almost doubles the one of urban areas and it is almost 5 times greater in women without schooling than in those who finished elementary

[47] For the country as a whole, adolescent fertility decreased by 42.8% between 1970 and 1995, from 126 per thousand to 74 per thousand (Table 1.4). There is no available information for the D.F. with which to compare these figures, but teenage fertility must have decreased in the capital at the

school (CONAPO, 1996:13). Although no systematic data for the D.F. are available, it appears that the age of sexual initiation has significantly decreased over the last fifteen years (See Chart 1.1).[48]

The prevalence of contraceptive use among adolescents is still quite low, though it has increased. Countrywide, while in 1992 the percentage of women in the 15-19 age group with a stable partner who used contraceptive methods was 36.4%, in 1997 it rose to 45% (CONAPO, 1997;1999). The proportion of unwanted pregnancies in this segment of the population, is very high (probably close to 40%). Though there is no reliable information about induced abortions, they probably represent at least one fifth of all pregnancies in this age group.

3.4. Epidemiological profile.

In terms of the epidemiological profile of adolescents in the D.F., the following facts stand out: mortality rates in the groups between ages 15 and 19 differ depending on sex. For males, the rate (3.3 per thousand) is 2.5 times higher than for females (1.3 per thousand) (INEGI, 1997a). Neoplasms and accidents stand out among the main causes of mortality among adolescents (see Table 1.5), holding the first places for both sexes and both age groups (10-14 and 15-19). Among women, complications of pregnancy, childbirth and puerperium also occupy an important place. Maternal deaths represented eight percent of total deaths among 15-19 year old females. AIDS has an important place among the causes of mortality for males in this age group (CONASIDA, 1999).

At the national level, the adolescent population (ages 10 to 19) accounted for 2.1% of the AIDS accumulated cases. The proportion of males with AIDS was three times greater than that of females. On the other hand, the fact that AIDS is increasing significantly in the 20-24 year age group is reason for concern, since most probably many contracted the disease before turning 20 (CONASIDA, 1999).

From the AIDS cases reported in Mexico up to 1998, the three main causes of infection among males in the age group 10 to 14 were: hemophilia (36.4%), blood transfusions (29.8%) and homosexual relations (6.7%). For women in this age group they were: blood transfusions (44.6%), perinatal infection (10.6%) and heterosexual relations (8.5%). In the 15 to 19 year age group, transmission in males was mainly sexual:

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same rate or more than it did at the national level for that period. The rate of adolescent fertility in the D.F. was under 50 per thousand in 1995 (CONAPO, 1996).

[48] This statement is based on information resulting from comparing several surveys carried out between 1983 and 1998. However, these surveys are not statistically representative of the population and are not strictly comparable, so an analysis should be done based on other data sources which can provide comparable information in order to verify the trend.

homosexual relations (32.8%), heterosexual (17.6%), and bisexual (16.4%); among females the main causes for infection were heterosexual relations (50%) followed by blood transfusions (20.1%) and drug use (3.5%).

Regarding other sexually transmitted diseases there is not much information about their incidence and prevalence among adolescents. However, some of the data available, taken from a survey carried out by the *Consejo Nacional para la Prevención y Control del SIDA* (CONASIDA, National Council for the Prevention and Control of AIDS) during 1992-1993, through a probabilistic sample of 15 to 60 year-old males living in the D.F., indicate that approximately 5% of adolescents between 15 and 19 years of age have suffered from a sexually transmitted disease sometime during their lives, and 1.6% presented this kind of diseases during the year previous to the survey. As for the type of STD, this group reported: hepatitis (4.7% sometime in their lives and 0.17% in the year previous to the survey), gonorrhea (0.77% and 0.41%, respectively) and condylomas (0.72% and 0.53%, respectively) (Chart 1.2).

Table 1.6 shows the main causes for hospital egression for the population as a whole in the D.F. (no figures for the adolescent population were available). The main causes among the female population were complications during pregnancy, childbirth and puerperium, followed by tumors and respiratory diseases. For males, traumatisms and poisoning were the most important causes, followed by respiratory and gastrointestinal diseases.

Addictions in adolescents are also a cause for concern. Tobacco, alcohol and other drugs are being used more every year, while the age of users decreases. Surveys in the D.F. show that in recent years secondary and preparatory school students have increased their tobacco consumption. It has risen from 46.5% in 1991 to 55.4% in 1997. Tobacco consumption was higher for males than it was for females according to 1997 figures. Regarding other drugs, the fact that cocaine now occupies the second most important position for this population, after marihuana, is alarming (CONADIC and SSA, 1999).

The number of cases at the *Centros de Integración Juvenil* (CIJ, Youth Integration Centres) in the D.F., a social assistance institution devoted to the prevention, treatment and rehabilitation of drug addictions amongst the young, increased by almost one hundred percent from 1993 to 1996 for males and by 150% for females. Most of the population that received treatment was between 15 and 19 years of age (Chart 1.3).

There is not much epidemiological information available regarding mental disturbances among adolescents, although it is generally accepted as an important

problem. In a study by Mariño and Medina-Mora (1994) with 873 secondary and preparatory students from the D.F., 15.4% were found to suffer from various symptoms of depression. These symptoms were more frequent among females than males (two females for each male). Most of the students with several symptoms of depression belonged to a low socioeconomic level. However, the most important differences between males and females were observed in the middle and upper socioeconomic levels (Chart 1.4).

Information on suicidal ideas[49] shows that 47% of students surveyed presented at least one symptom in the year previous to the study, 17% reported having thought about taking their own life and 10% answered yes to the four symptoms that were studied ("I couldn't go on", "I had death wishes", "I felt that my family would be better off if I were dead", and "I have thought about killing myself"). The presence of at least one suicidal symptom was observed in a slightly higher proportion of females, with some variations depending on age between the ages of 13 and 19 (Table 1.7).

Finally, another important health problem, affecting adolescent females more than males, is family violence. According to information from the *Centro de Atención a la Violencia Intrafamiliar* (CAVI, Centre for the Attention of Intrafamily Violence), from all the cases attended (9,691) in the D.F. from January to September 1997, 85.6% were females while 14.4% were males. Distribution by age shows that the group of age between 13 and 19 represents 3.2% while the one of ages between 18 and 24 represents 18.7% (the second highest of all age groups)(Table 1.8)(*Procuraduría General de Justicia del D.F.*, 1997, quoted in *Gobierno del Distrito Federal*, 1999).

3.5. Summary.

To summarize, it can be said that the situation of adolescents in the D.F. is still privileged inasmuch as they have access to education and health facilities. Nonetheless, this hides enormous inequalities that are not reflected in the available statistics.

In spite of this privileged situation, there is reason for concern given the violence, insecurity and uncertainty adolescents perceive regarding their future, as well as the adoption of risky behaviors characterizing growing sectors of this population, which are reflected in an increase in the number of accidents, wounds, addictions, sexually transmitted diseases -including AIDS- and suicides.

[49] From the National Survey on Drug Consumption among the Student Community (IMP and SEP, 1991). Among students from the D.F., results are based on a total of 3,459 students between 11 and 21 years of age, 51% of which were males and 49% females.

The reasons for the significant increase in adolescent mortality due to neoplasms, in both sexes, should also be looked into.

Chapter 4. Providers' perspectives.

4.1. General perspective of the providers.

Both services consider sexual and reproductive health as the autonomous and responsible exercise of sexuality, with the purpose of avoiding negative consequences, like the possibility of pregnancy or contracting a sexually transmitted disease such as AIDS. References to enjoyment or satisfaction in sexual relations are absent from the statements of the providers. Adolescent rights are recognized as receiving information, orientation, medical and psychological services related with their sexual and reproductive health, as well as the decision on which birth control method to use. Providers understand gender as socially determined roles in the field of reproduction, which imply inequalities affecting female adolescents more than males.

Both services emphasize the need to take a holistic or comprehensive approach to adolescent health. For health providers at the Module, a comprehensive approach means "to see the person in a holistic manner, in all its aspects, biological, psychological and social". This also implies interdisciplinary work. Health providers at PREA also indicated that a comprehensive approach to adolescent health meant "not to separate the medical from the psychological and social problems; to consider the three spheres and attain an interdisciplinary work, as a team".

The health personnel favors the adoption of contraception, but neither service encourages dual method use and males are almost always excluded from this activity. Pregnancy is considered a problem, particularly for young women, since it makes it difficult for them to finish their education or to have other experiences considered important in adolescence. However, this standpoint does not consider that many adolescents had left school years before and wished to have a child, despite the economic or family difficulties this might imply. The diverse connotations childbearing has for adolescents -which may be positively valued in certain conditions of socioeconomic restriction- are not considered. On the other hand, the intention to terminate a pregnancy is discouraged by providers at both services, because this procedure is illegal in Mexico. Violence and addictions, while recognized as a growing problem in the adolescent population, are detected but few services to attend to them are provided either at the Module or at PREA.

4.2. Parental authorization.

Though parental authorization is not a requisite in order to provide assistance to adolescents, in the “En Buen Plan” Module the youngster is asked to be accompanied by an adult, especially in the case of pregnancy. The reasons to proceed in this manner are:

> "*Because the doctor always has to have a grown up that is able to make sensible decisions according to what the doctor specifies as treatment or as recommendations regarding family dynamics*" *(Provider 2, Female, En Buen Plan Module).*

Similarly, another provider states:

> "*They must come with a relative or an older brother or sister at least... because this implies that they are committed to improving the young person's health too” (Provider 4, Female, En Buen Plan Module).*

If the adolescent arrives alone:

> *"...They always receive attention, they receive attention but always in the presence of the nurse or myself... they are [given] instructions for their next visit... they must come with another person, a grown up” (Provider 2, Female, En Buen Plan Module).*

As it can be seen, the providers seem to consider the adolescent as a subject who is not responsible for his/her own health and who needs to attend appointments with a responsible adult in order for him/her to follow the prescribed indications or treatment. However, it seems that when the appointment is only in regards to birth control methods, this requirement is not mandatory:

> "*Many even come alone and do not want their parents to find out, ...they come and say, 'You know, I want you to tell me about birth control methods, but nobody knows anything about this in my house, I mean, I am going to start my sexual life but my mother would not approve', then their decision is respected, they receive the orientation and, as we tell them here, it's your decision... Our work is to guide them and tell them about the risks, about everything involved in the responsibility of starting a sexual life and the decision... that is definitely hers...” (Provider 2, Female, En Buen Plan Module)* .

At the PREA we were informed that the authorization of a parent or legal guardian is not necessary for receiving attention, with the exception of certain surgical procedures such as tubal ligation for which this permission is necessary. In the case of underage adolescents who arrive alone at the hospital to give birth and who present with drug or prostitution problems, when they have the baby they are taken to the attorney's office and a suit is filed for the abandonment of two minors; the hospital functions as responsible for both minors and the young mothers are taken to a shelter, either with the baby or alone.

4.3. Birth control.

Birth control counselling consists in *"giving them the confidence, security, trustworthiness and information on all the existing methods" (Provider 3, Female, En Buen Plan Module)* emphasizing the benefits of family planning.

All staff at the "En Buen Plan" Module said that they provide information regarding all existing methods,[50] including the so-called natural methods, as exclusive breast feeding for six months (the Lactational Amenorrhea Method) and withdrawal. After the corresponding medical examination, the doctor offers the methods available at the Module[51].

Regarding the criteria used in order to recommend a specific method, the answers provided by the health staff at the Module included the reference to the Official Mexican Norm for Family Planning,[52] the physiological conditions of the adolescent, as well as the intuition of the provider regarding the degree of responsibility or irresponsibility of the young woman to use a method correctly.

> "...*Let's say, if we see a girl that we truly know is not going to come every month for her pills of for her shots, then the most practical thing is an IUD; then if we see that the girl is going to come, if she is responsible and she is going to come to get her shot, then she is given the injection" (Provider 3, Female, En Buen Plan Module).*

Frequency of sexual relations is probably the main criterion taken into account when the use of a condom is suggested.

> "*To young couples with not very frequent relations, precisely because they are not married, they do not want their parents to find out, then their relations are going to take place every fifteen, twenty days, they are the ones that we give the condoms to on the first visit" (Provider 3, Female, En Buen Plan Module).*

In order to encourage the adoption of a birth control method, PREA offers daily lectures for adolescents hospitalized for any obstetric event. In the pre- and post-natal courses, young mothers are also encouraged to adopt a method and are provided with informative brochures. The method that is most recommended when the adolescent has had a normal birth, a C-section or does not have any disease, is the IUD. If she has an infection, condoms are suggested until the infection has receded. The reason IUD use is encouraged is, according to the service providers, that the adolescent will be breast feeding, so it is not possible to give her a hormonal treatment.

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[50] Information given to adolescents does not include emergency contraception, though we were informed that they had given it twice.

[51] Apparently, a shortage of birth control methods is not uncommon. Not very long before the interviews, they spent approximately five months without condoms, which means that even if they provided information regarding this method, adolescents had to get them on their own.

According to the providers, the key factors for adolescents adopting a contraceptive method and continue using it were: the informative support of mass media, the sexual education programs at schools, the labor of health personnel, that the patient had undergone some experience that put her at risk of getting pregnant, and that the promoters themselves were young people. As obstacles, they pointed out unaffordable prices, shame, religious beliefs against contraceptive use, personal or family beliefs regarding the negative side effects of contraceptives, the fear of social disapproval or rejection, particularly from the providers (health personnel or pharmacists), lack of information, irresponsibility and established gender norms and roles.

Regarding the issue of gender roles, the staff mentioned the difficulties for males to approach the service inquiring about a method or about using condoms:

> "*Yes, it is more difficult for the men to adopt a method than for the women, for the role that we have... established... for each sex, that is, the woman is the slave, the woman is the one that must get her tubes tied, the woman is the one that has to get the IUD and I believe this is passed on from generation to generation" (Provider 4, Female, En Buen Plan Module).*

Regarding the factors that obstruct the adoption and continued use of a birth control method, the PREA personnel gave the same list as the "En Buen Plan" Module staff in Iztapalapa, but they emphasized that female adolescents without a partner are the most reluctant to adopt any method after giving birth because they believe they will not have a partner or sexual relations again. They also mentioned that often the greatest obstacle for the adolescent to use a method is the opinion of her partner or her parents, who are against her using a birth control method.

Finally, all the interviewees at both services considered that in their daily work they prevented both pregnancy, and STD's (including HIV/AIDS). However, during counselling, when they pointed out the aspects linked to practices that could put adolescents at risk, we noticed that there is a greater emphasis on providing orientation regarding contraception. This was evident in the fact that there were no prescriptions for dual method use in either service.

4.4. Pregnancy.

The Module offers the following services for pregnant adolescents: pre-natal care and a yearly one-week long course on "Pregnancy and Childbirth." In the eighth month of pregnancy, the adolescent receives a pass for a medical institution where she will deliver her baby. Psychological attention is sometimes provided:

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[52] Which establishes the medical criteria for using each of the approved methods.

> "*Under the circumstances where the pregnant adolescent is in a depressed state, be it for the rejection brought about by her pregnancy, because she does not count with the support of her partner or that he abandoned her or because her family openly rejects her, then there is intervention... trying to improve her self-image, reinforcing self-esteem and creating in the patient a life goal focused on the future, proceeding, if the doctor or the pregnant patient considers it necessary, to an intervention with the partner as well as with the family" (Provider 1, Male, En Buen Plan Module).*

The Module promotes the involvement of the partner and of the family of the pregnant adolescent. They are invited to attend the monitoring appointments with the young woman with the purpose of making them responsible and prompting them to support her, for it is considered that:

> "*The problem is multifaceted and mainly there is a lot of family conflict, there is a lot of aggression, lack of family integration, then we try to involve the whole family because finally the problem sometimes is not the girl but her environment, her family" (Provider 4, Female, En Buen Plan Module).*

The PREA personnel also said that they consider family and partner involvement important, but that it is difficult to achieve.

The providers at the Module showed concern for the pregnancy of an adolescent, both because of the antecedents that led her to get pregnant and its consequences. Looking for love, the need for affection, self-satisfaction and self-realization through having a child are identified as some of the main motives that lead an adolescent to get pregnant, according to the psychologist. Moreover, the doctor considered that the main cause for these pregnancies is a lack of proper sexual education. Another provider, however, stated:

> "*...I feel it is the young women, most of whom want to get out of their houses, they have problems and the only way out is getting pregnant... there are still more pregnancies than one would like" (Provider 3, Female, En Buen Plan Module).*

The responsibility a child implies, more so when there is no support from the father or the family, and the limitations to continue studying, are the consequences perceived as the most important ones of a pregnancy at this stage of life. The PREA personnel agreed with this and considered that adolescent pregnancy is a problem:

> "*Something that should not happen at that age, for it is an age to study, to go out, to have fun, to meet boys; they go from being girls to being women and with their pregnancy they are stuck at home..." (Provider 1, Female, PREA)*.

Even though, according to the providers, the problem of pregnancy is located in the social environment, they handle it from the medical-psychological perspective, giving a

subordinate role to the socially determined representations that value maternity and the multiple meanings associated with this experience in certain sociocultural contexts.

4.5. Sexuality.

The Module addresses the issue of sexuality during the lectures it gives to adolescents and educators. The staff organizes an annual course, under the title "Adolescence, Sexuality and Health," aimed both at adolescents using and not using the Module; however, a different approach to the problem for female and for male participants is not considered. There was only one situation where it was possible to detect some differentiation between females and males:

> "*They receive guidance about the risks, about everything involved in the responsibility of starting a sexual life and the decision, that is definitely hers, because we even tell them that she should never feel pressured by the boyfriend asking her to prove her love or forcing her to have relations; no! The decision should be hers...” (Provider 3, Female, En Buen Plan Module).*

In this quote it is also possible to detect an orientation, that is apparently the one which prevails, stressing risk prevention in the field of sexuality, as if this only implied dangers and not pleasure and gratification.

Service providers expressed the intention of involving parents in the short courses provided by the health personnel in the future.

The PREA takes on the subject of sexuality in its post-natal lectures. The staff considers that these sessions have had a favourable impact as the adolescents do not have other spaces where they can voice their doubts, their concerns and their fears about sexuality.

4.6. Violence.

Family violence -both in the family of origin and with the adolescent's partner- though not a direct or frequent motive of appointments, is perceived by the Module's personnel as an important and growing problem.

> "*Yes, there are cases, yes we detect family violence, but unfortunately it is not in an open way, acknowledged by the patient. The one that is punished, that is hurt the most, is the woman, but they never talk about it like that” (Provider 2, Female, En Buen Plan Module).*

As for the treatment a patient receives, providers stated that their purpose is, in the first place, to create the necessary trust so the young woman can open up and say what is happening to her. Providers listen to her and try to find ways of helping out or channeling her to institutions that work specifically in the kinds of problems she is having. If the patient shows evidence of abuse, she is channeled to the DIF. If the case is rape, she is

channeled to the Agency of the Public Ministry Specialized in Sexual Crimes. In the cases where the health team and specifically a psychologist intervene, the involvement of the parents is suggested. Generally the mother attends the appointment with her daughter. Frequently, the adolescent and her mother drop out.

The most frequent kinds of violence that are detected are family violence of the mother towards her children, abuse by mothers-in-law or the adolescent's partner, threats ("*if you do not live with me I will take the children away from you or I will make the children that you have 'disappear'*.") and confinement. The health team does not carry out preventive activities regarding violence, neither in the service nor in the community.

The PREA's health staff perceives family violence as a problem that affects some adolescents and which has two distinguishable forms: physical violence from partner and psychological violence from parents. In these cases, the team's psychologist cares for the patient. In severe cases, this professional assists the adolescent for a period of four or five sessions, with the purpose of sensitizing her about attending an institution specialized in this kind of problem. She is referred to one of these institutions. The lectures provided by the service also deal with the subject of violence.

4.7. Drugs, alcoholism and other addictions.

According to the health personnel, addictions are a growing health problem among adolescents and young people. In particular, the psychologist and the nurse of the Iztapalapa Module have observed changes in the characteristics of this phenomenon that are manifested by an increase in the female population with addiction problems, a decrease in the age young people start using these substances and a change in the substances they are using, which are now more varied. In addition, use of strong drugs, such as cocaine, is starting to become more prevalent.

From time to time, schools send adolescents to the Module if they are found using drugs inside the school grounds. In other cases, during the clinical interview some habits or behaviors are detected that may be associated with addictive behaviors. The cases that are observed are sent to Youth Integration Centres.

Even though the service does not provide treatment for these problems

> "*We speak with the parents about drugs, their effects and the attitudes and care they must have, making them participate and become responsible and effective, not feeling guilty or placing the guilt somewhere else" (Provider 1, Male, En Buen Plan Module)*.

As with many other health problems affecting adolescents, the causality is found in a deficient communication between parents and children and in the dysfunctional structure

of families. The providers do not carry out any prevention tasks, neither in the service nor in the community.

The health personnel at PREA also consider that drug addiction is a problem observed in the population they serve. Frequently, the young women state that both they and their partner use drugs and that they fear for the health of their baby. In these cases, the psychologist offers individual attention and if the case is deemed serious the person is channeled to a Youth Integration Centre. The lectures also deal with the subject of addictions and brochures are handed out.

4.8. Abortion.

Health care staff in the Module mentioned that few adolescents say that their pregnancy is unwanted.

> "*Well, many girls say that they had not contemplated getting pregnant, but when they had found out they were, they accepted their pregnancy... we have had some cases, but as I say, they are uncommon" (Provider 3, Female, En Buen Plan Module).*

In these cases, they are sent to the psychologist who tries to make them accept their pregnancy.

> "*We first try to get to know the motivations she has to think about having an abortion, and if we do not find a legal cause that justifies it, then we try at all costs to illustrate how marvellous maternity can be for this young woman... all the same she is told that she is free to decide, that she must be responsible, self-sufficient and that the service will respect her decision but that we are not allowed to favor a situation that goes against the law in force" (Provider 1, Male, En Buen Plan Module).*

> "*Here we are not allowed to have abortions, we cannot help her with that; now, it is her decision, right? But at least within the unit we are not allowed to give her an abortion option; if she decides to go ahead with the abortion, it will have to be outside the unit, but it is not allowed here, that we give options for an abortion" (Provider 3, Female, En Buen Plan Module).*

The words of these professionals allow us to see what their views are regarding unwanted pregnancies, making it evident that they try to convince the adolescents of the virtues of maternity and to discourage abortion. However, after emphasizing the possibility of choice, the adolescent is left alone in case she decides not to have the baby --which probably should be a cause for greater concern.

At the PREA, service providers stated that they discourage those adolescents that arrive at the service asking for assistance in interrupting their pregnancy.

> "*They are told about the risks of clandestine abortions and we try to motivate them to talk with some relative if they are going to go along with it, so someone close to them is aware of what is happening and so that at least they know her whereabouts" (Provider 1, Female, PREA).*

The service, in these cases, does not assume any responsibility over these young women. On the other hand, we were told that few adolescents do not accept their child once it is born. In these cases, the service offers orientation about the possibilities of giving it up for adoption. In the cases of spontaneous abortions, the psychologist offers therapeutical support.

4.9. Relationship with the community.

The Iztapalapa Module keeps in touch with elementary schools and secondary schools where they offer lectures on sexual education for students and teachers. The main difficulties found in working with the community are, according to the providers, the great demand for appointments -that hinders the development of external activities-, the lack of educational material, and the impossible task of caring for the whole population of the zone where the health centre is located since it is very large.

The PREA does not carry out any community work.

4.10. Links with other institutions.

Both the Module and PREA keep in touch with other institutions where adolescents are channeled in case it is considered convenient or necessary.

Chapter 5. Users' perspectives.

5.1. Links with the service.

Most of the users interviewed knew about the Module through direct relatives or in-laws (mother-in-law, father-in-law, sister-in-law). In some cases there is a prior knowledge of the Health Centre where the Attention Module is found, where they have gone to receive attention for other problems, to get health certificates or for other reasons. None of those interviewed knew of another similar service that cared exclusively for adolescents and young people, though they all pointed out they knew about other private and public health care providers. Two of the adolescents stated that they had gone to the IMSS clinic before

but that currently they were no longer its beneficiaries.[53] Three of the adolescents sought care from other institutions before they arrived at the Attention Module.

Reasons for selecting this service that stand out are: previous knowledge of its existence, the recommendation of the service by some relative, good care, closeness and low cost.

In the case of PREA, the main sources of knowledge regarding the hospital came from relatives, friends or medical professionals and the election of this service is based on the recommendations of those who once received good treatment there.

From the fifteen interviewees at the Attention Module, three were first-time users. The rest of them had already started getting care through this program. All those interviewed, with the exception of one adolescent, thought the schedule was adequate. Seven young people considered the waiting time too long. For the rest, the waiting time was reasonable. At the PREA, six adolescents said the morning schedule was more convenient, two would rather go in the afternoons and the rest thought that any schedule would be all right.

The users of the Module mostly utilized collective transportation to get there (collective taxis, buses, subway); four indicated that they had gotten there walking and one used a taxi. Transportation time to the Module is between 40 and 45 minutes, while those who attend PREA took between 10 and 90 minutes to get there.

5.2. Reasons to attend.

In 10 cases, the main reason to attend the Module was pre-natal monitoring, three were looking for a birth control method and two were there for psychological consultation. Most of the adolescents go with their partner, their mother or their mother-in-law. Fourteen of the fifteen interviewees said they received exclusively the health service that their consultation was about; that is, medical or psychological attention.

Among the main reasons to attend the PREA, the following stand out: participation in pre- and post-natal lectures, new-born care, psychological consultation and medical consultation for post-natal care/monitoring or to supply or supervise birth control methods. In some cases an adolescent may receive two health services on the same day, for example she may attend a post-natal lecture and take her child for care or she may participate in a group session and then have an appointment with the psychologist. Seven

[53] Daughters of IMSS beneficiaries stop to be considered family dependants when they become pregnant, independently of their age and civil status (or marital situation).

interviewees attended with a relative (aunt, sister, grandmother, father) or with their partner.

5.3. Pregnancy, knowledge about STD's and HIV/AIDS.

Among the main health problems the Attention Module interviewees saw among adolescents were, in order of importance, unwanted pregnancies, sexually transmitted diseases, AIDS, alcoholism, smoking and drug use.

Crime and violence were only mentioned by two of our subjects. It is worth noting that the lack of communication between parents and children, family problems, and insecurity in adolescents were signaled as the main causes for the problems currently affecting this sector of the population. Correspondingly, adolescents proposed solutions within the family group in order to solve these problems through communication, collaboration, support and orientation from the parents. They also mentioned the help of some groups such as the CIJ or the *Grupo de Alcohólicos Anónimos* (AA, Alcoholics Anonymous), as well as the need for informative campaigns at entertainment centres, gyms and discotheques.

The attitude of professionals treating young people with these kinds of problems is an important issue. As one interviewee said:

> "*...They should not show up as what they are. They should not show up as doctors, as teachers, but simply as friends... a friend that tells them what is wrong, what is right. Many people will not accept it or they won't listen to them, but there will be many people who will accept what they are and who will accept what they are going through... It is very important to be a friend and not a professor or a doctor, who only sees you, deals with a specific problem and that's it" (User 4, Female, En Buen Plan Module).*

Among those interviewed at PREA the same health problems were pointed out as those in Iztapalapa's Attention Module, though other sexually transmitted diseases such as gonorrhea and condylomas were also mentioned. Regarding the problems that were identified, using condoms was one of the strategies that most of the young people pointed out in order to solve them. Other activities that were considered indispensable were: lectures and supply of birth control methods at schools, information activities and orientation in health services regarding the importance of taking care of the body, psychological attention, lectures to parents and information through the media. Only one adolescent indicated the need for more communication and trust between parents and children.

Fourteen out of the fifteen interviewees at the Module said that their families were aware that they were going to the service. Relatives supported the adolescent going to the

Attention Module, particularly in cases of pregnancy, which is a process that families consider requires supervision.

At PREA, three out of the fifteen subjects we spoke to said their parents were not aware they were attending the service because they were not on speaking terms with them. However, in these cases, other relatives did know about their attending the hospital, their opinions were favourable and they offered their support.

5.4. Satisfaction regarding the consultation.

In the Module, all those interviewed stated that they had received the information and the health services they required, the relationship between the provider and the patient was seen as adequate and the treatment provided was considered good. Regarding the sensation of having learned something new and clearing up doubts after the consultation, most of those interviewed were satisfied; however, only half were able to say exactly what they had learned or what doubts they had cleared up. Some pregnant adolescents commented that they learned about their pregnancies, of how to care for themselves and eat *"so the baby comes out all right"* and that pregnancy changes life completely. None of those interviewed considered that they received more information than they requested from the providers. As for the possibility of asking, half of the young people considered that this option existed, though the other half pointed out that: "*I almost never ask anything" (User 10, Female, En Buen Plan Module).*

The providers' willingness to listen was confirmed by all the adolescents and one of the users considered it a characteristic and quality that every provider dealing with adolescents should have. In a similar way, all the interviewees pointed out that the language used by the provider was clear, simple and understandable and that they were told when they should return.

In the same way, users at PREA considered that the services they received were satisfactory and that they received the information and attention they required. They felt that the information they received "reduced their fears" and that it is useful to learn things they did not know, for example, about caring for the baby. Three adolescents considered that they received more information than they asked for and nine stated that the providers had cleared up their doubts. The possibility of asking exists; however, some of the adolescents commented that:

> "*I do not ask questions because I am afraid that they might answer something I won't understand" (User 1, Female, PREA).*

"*There are doctors that are grouchy and you don't feel comfortable asking them questions" (User 2, Female, PREA).*

"*I am embarrassed to ask them a question" (User 11, Female, PREA).*

Most of the adolescents (ten) said the language used by the health agents was clear, though some considered that:

"*At the beginning it is a bit confusing, but afterwards they explain more carefully" (User 2, Female, PREA).*

"*They talk too fast and some things remain unclear and afterwards I no longer know what to do" (User 13, Female, PREA).*

"*No, I really didn't understand very well" (User 11, Female, PREA)*.

Most of the patients at the Attention Module and at PREA expressed their open preference to be seen by a woman doctor. The link of greater confidence that is achieved with a female doctor is highly valued by the group of interviewees. The adolescents voiced their opinions about how they feel when being examined by a man doctor; they feel self-conscious and embarrassed or uncomfortable.

All interviewees considered the cost of the consultation at the Attention Module as cheap and very affordable. On the other hand, at PREA in the Women's Hospital, the perception of the cost differs according to the services received. While the cost of a medical consultation is considered cheap (U.S. $2.65), the cost of hospitalization is considered expensive.

The main reason for which users have recommended or plan on recommending the services provided by the Attention Module is the good care they have received. Adolescents at PREA consider that the good care they received, the perception that they are learning and the feeling that they are being helped and motivated to succeed are the main reasons to recommend the service.

While most of the interviewees considered that their friends might eventually attend the Attention Module for information and counselling regarding sexuality, orientation in an unwanted pregnancy, information and supply of birth control methods or to have an HIV test done, they emphasized the former aspect of the good care received as the main reason that friends might attend.

5.5. Privacy and confidentiality.

All the adolescents using the Module considered there was privacy during the medical consultation.[54] Most adolescents attending a medical consultation at PREA pointed out that the nurse was present; however, this is not considered to be a lack of privacy.

In the case of pregnant adolescents, the doctor at the Module asks for a blood and urine test as well as an ultrasound. Though those interviewed considered that the doctor did explain what these tests were about before they were performed, their answers show that they are informed about the preparation prior to the test (having nothing to eat since the previous night), the characteristics of the sample (first urine of the day), where to take them to in the hospital or how to make the procedure at the hospital quicker, but they did not have information regarding the purpose of these tests.

On the other hand, the patients at PREA who were asked for these same tests answered that the doctor did explain what the analyses were for.

As for the feelings experienced during the consultation, medical or psychological, practically all the interviewees at the Module said they felt well, comfortable, safe and calm. Most of the adolescents attending PREA expressed that they felt calm, they trusted the personnel and they felt at ease as a consequence of the treatment they received.

5.6. Information, education and communication.

None of the adolescents we interviewed at the Attention Module received information brochures from the health personnel; nor did they participate in group sessions. On the other hand, twelve out of the fifteen young women had the chance to read the posters in the waiting room. They remembered the subjects these posters dealt with in detail and most of them commented that they understood the information, that it was useful to have more information or correct information, to know the different birth control methods, to *"clear up doubts" (User 5, Female, En Buen Plan Module)* or to *"think about their relationship with their partner" (User 12, Female, En Buen Plan Module)*. This leads us to say that users recognize that they learn from reading this visual material.

Eleven out of the fifteen adolescents attending PREA said they had read the information brochures they were given by the personnel at the service as well as posters at the facilities. They knew the subjects dealt with in these materials. Every one of them had shared the information with their partner, brothers and sisters, other relatives and friends, or was planning on doing so.

[54] It is important to mention that when the adolescent is accompanied by her partner, mother or mother-in-law, they come along into the consulting room, when the provider should be expected to ask the patient whether she wishes them to come in with her or not.

All the adolescents participated in the lectures offered by the service and they spoke about their satisfaction, since they felt they had learned about:

“How to care for and feed the baby” (User 1, Female, PREA).

"*How our bodies change during the first and the last months” (User 2, Female, PREA).*

"*How to use birth control in order not to have so many children” (User 3, Female, PREA).*

Finally, and regarding the suggestions to improve the services, eight adolescents said Iztapalapa's Attention Module had to have another doctor given the large number of patients that go there every day, that there should be a better way to give out the turn cards, that the service should have ultrasound equipment, that the Module should have more diffusion and publicity and that:

"*When they publicize it they state the exact address, that it is free and confidential” (User 11, Female, En Buen Plan Module).*

Almost half of those attending PREA suggested that in medical consultations doctors should not "scold" the patients, that they should let their partners come in and that the doctors should not answer with a bad attitude. Similarly, the patiens said that there should be more publicity regarding the program so more young people know about it, especially young men; that the service should be promoted at schools and that people should participate more in the lectures.

Chapter 6. Final considerations.

6.1. The Influence of the Cairo Conference.

As it has already been pointed out, the Cairo agreements had a great influence in Mexico regarding the creation of new programs or the channeling of funds for health problems and women's rights from a gender perspective, as well as in a favourable change in attitude towards the activities of non-governmental organizations in this field. Similarly, decentralizing many public policies turned out to be a favourable condition, opening communication channels between non-governmental organizations and government agencies, though there is still a long road ahead for better coordination and greater cooperation. On the other hand, reorganization of the health services along with the greater demand for care rising from high levels of unemployment (which leaves a significant percentage of the population without medical coverage), as well as a reduction

in public resources destined to the health sector as part of structural adjustment policies, have resulted in lower quality of services and a shortage of medicines.

As for services in the field of adolescent sexual and reproductive health, the Cairo Conference reinforced the actions that the Secretariat of Health had already started. The main recommendations were included in the PNASRA. However, these recommendations have mostly remained on paper and have yet to be put into full practice. Regarding PREA, Cairo did not have any influence. The personal in charge of the program were not even aware of the Conference and its bearing on the work they are doing.

In terms of institutional arrangements, it was detected during this investigation that there is practically no link between the different state and federal agencies that carry out activities related with adolescent health services in the D.F., nor between the primary and secondary levels of care. There is no central agency that favors coordination between these agencies.[55]

6.2. Comparison between what is said and what is done.

A comparison between what is stated in the programmatic documents and what was observed in this research leads to the conclusions that follow.

6.2.1. General considerations regarding the programs analyzed.

Though the explicit intent of both programs is providing services for all adolescents, women are their main recipients.

Since both programs operate within institutions of the health sector, their clientele is constituted mainly by people seeking services related to their physical and psychological wellbeing (including prenatal, partum, and postpartum care). "Healthy," non-pregnant adolescents are, therefore, not a natural clientele for them, a fact that is clearly reflected in the profile of users of the services who were interviewed (see Appendix 1). Therefore, services are oriented less to pregnancy and STD prevention (development of competence for negotiating abstinence or safe-sex, etc.) than to health care and secondary prevention.

[55] The Assistant Director of PNASRA claims that the Program, and particularly coordination betwen the Federal and the State levels, functions much better in states others than the D.F., an issue which might have to do with the very recent (1998) decentralization of federal health services to D.F. authorities, particularly in view of the fact that elected authorities in the D.F. in 1997, for the first time in the history of the capital, belong to a political party (the *Partido de la Revolución Democrática*, *PRD*, Party of the Democratic Revolution) different and opposed to the dominant *Partido Revolucionario Institucional, PRI*, Party of the Institutional Revolution), which holds executive power at the Federal level, reason for which the transference of administrative authority from one government to the next was more complicated and took longer than usual.

To some extent, then, it can be said that both programs intervene too late, on already existing "problems" (pregnant adolescents or adolescent mothers), and would need to be re-oriented in order to reach adolescents before they engage in behaviours that might lead into problematic situations with regard to their sexual and reproductive health.[56]

Although health providers consider that their work has a favorable impact in terms, for example, that adolescents come back to the Module and to PREA after giving birth, in order to look for a contraceptive option, they recognize that their impact on the most important health problems affecting the adolescent population is scarce. They also recognize that it is fundamentally preventive work at the community level which should be undertaken. As it has been mentioned, this kind of work at the Module is recent, non-systematic and secondary with respect to the assistance services given.

The professional and affective compromise of the health personnel at both services in their attention to adolescents, in spite of the various difficulties their confront, should be underlined.

6.2.2. The *Programa de Atención a la Salud Sexual y Reproductiva de los Adolescentes*

Though the program mentions holistic health for adolescents of both sexes, it mainly focuses on their reproductive health. A gender perspective and reproductive health services as a right of adolescents are mentioned; however, there is no outline on how to translate these principles into the activities within the services.

In fact, in the Module, health team activities are mainly oriented towards providing information, orientation and counselling about family planning, psychological orientation, supplying birth control methods, and providing pre-natal control for pregnant adolescents. Though the program stresses the promotion of condoms as a way of preventing pregnancy and sexually transmitted diseases, putting this into practice on a daily basis is hindered by the shortages in their supplies.

As the providers point out, a set of institutional limitations, as well as a lack of human and physical resources, are factors that prevent the service from complying with its original purpose: reproductive and sexual health promotion and prevention. From the

[56] Whether primary prevention should or should not remain as one of the more important objectives of these programs, or whether it is within the health sector that primary prevention can best be addressed, are questions that ought to be confronted but that lie beyond the scope of this investigation. Since they are part of the objectives of the programs analysed, however, we do address the program's shortcomings in this regard.

providers' point of view, the greatest impact of the program has been in the field of secondary prevention, which is an accurate statement. Primary prevention activities are basically restricted, within the service, to the courses/workshops for adolescents and for pregnant adolescents and, at the community level, in recapturing "run away" users and giving lectures at schools for teachers and students. Parents are mostly excluded from the activities.

Regarding a gender perspective, although verbally there is a certain degree of recognition of gender inequality connected with sexuality and reproduction, and of the difficulties of getting males involved in the decisions linked with their sexual and reproductive health, this does not come from formal training at a central institution, nor does it translate into systematic actions within the service. In this sense, the health team's participation in the GIRE meetings may be considered as acquiring information about gender-related problems and as an important medium to attain a higher level of awareness. However, since the authorities at the Health Centre ordered them to stop participating in these meetings, this training has come to a halt.

Regarding the rights of adolescents, health agents put special care in promoting the right to information and counselling in the subjects of family planning, STD's, and HIV/AIDS, as well as the right to choose the birth control method that adolescents consider the more appropriate. Nonetheless, the service does not explicitly emphasize the situation of adolescents as subjects with active rights and as agents that should demand these rights and defend them, nor is there a special awareness towards the importance of adolescent participation in the programs.

Though the cost of the services provided by the Module is affordable, the schedule excludes adolescents that go to school in the mornings, and most of the activities they develop do not promote effective male attendance.

6.2.3. The *Programa Educativo para Adolescentes* (PREA).

PREA's programmatic document emphasizes informative and educational strategies aimed at pregnant adolescents and adolescent mothers, though it mentions that information and integral attention will be available to the open population of adolescents of both sexes. The concept of reproductive health that prevails in the program is restricted to the importance of planning the number of children and child spacing, by delivering to adolescents the correct information that will allow them to exercise their sexuality responsibly. The document does not mention sexual and reproductive rights of adolescents, though it may be inferred that the right to information, education and attention

in this field is implicit. There is no mention of a gender perspective either. Although permanent supervision and evaluation mechanisms are mentioned, it is not considered that adolescents should participate in them.

In our opinion, there is congruence between the main programmatic objectives and the service activities carried out by the multi-disciplinary team. However, the inclusion of males as a target population is insignificant and their problems are not specifically included in the program. Similarly, there is no attempt to increase the little participation of the family and the adolescent's partner to deal with problematic situations. It is important, however, to point out the inclusion of self-esteem in the lectures as one of the pivotal ways to develop assertiveness among young women.

6.3. Recommendations.

Based on the research, a series of suggestions and recommendations follow, considering the current situation of the programs analyzed.

6.3.1. With regard to the formulation, execution and evaluation of the programs:

- Programs could start from recognizing the influence of the family and community environment, where the behaviors of the adolescents take place, and to detect favourable and unfavourable factors that lead to risk behaviors. This diagnosis could lead to the identification of different interests, needs and possibilities of the adolescent population depending on their sex, age, main activities, level of education and life situation and experiences.
- Based on this diagnosis, a more comprehensive approach could be developed in the service, focused on adolescents and their families, their peers and their community environment; an approach which would have prevention and promotion of positive behaviors in young people as its foundation.
- It would be desirable to incorporate social science professionals (anthropologists, sociologists, experts in education and communication) in program and strategic planning, so that socio-cultural aspects related to health-prevention in adolescents are included.
- The concept of prevention needs to be broadened to include recreation activities, self-esteem, decision making, assertiveness and acquiring competence, for example to resist peer pressure or to problem solving.
- Furthermore, it is also suggested that the participation of adolescents in identifying the needs and the design of the service and its activities should be promoted. It is well

known that, when young people participate actively, their presence and the respect shown to them contribute to attracting more young people.

- Greater effort is recommended in the coordination, collaboration and links among different governmental and non-governmental agencies involved in adolescent reproductive and sexual health. This could be done through a diagnosis of the services provided and the identification of possible links between them.

6.3.2. In relation with the training of health personnel:

- Make providers better aware of the socioeconomic and cultural conditions that prevail in the environment where service users live and of what these conditions imply in terms of the options, possibilities and limitations regarding working with their clients in order to modify behaviors.
- Increase the agents' awareness regarding problems such as abortion, addictions and violence in all its forms, particularly sexual and gender violence, as well as the links between addictions and protected sex, or violence and the possibility of negotiating preventive strategies in the sexual relation.
- Promote programs recognized by graduate academic institutions for the training of health professionals and paramedics in the specialization of adolescent medicine.
- Train service providers with regard to: the characteristics of adolescence and its problems, a holistic approach to sexuality, and gender perspectives and rights.
- Train the health personnel so they can carry out educational activities.
- Implement incentives and encouragement for the health personnel, favoring their participation in courses as well as the collaboration with personnel from other institutions also devoted to adolescent care.

6.3.3. In relation with the provision of services:

- Increase service days and extend schedules with the purpose of including adolescents who are excluded from the service (for example: the population that goes to school, the working male population, etc.).
- Give greater promotion to the program and the modules, providing addresses, schedules, and emphasizing privacy and confidentiality in the services.
- Improve the organization of the establishment of turns in order to decrease waiting time.
- Increase prevention, detection and treatment of sexually transmitted diseases.
- Emergency contraception and dual-method protection ought to be vigorously incorporated into the services, with proper counseling and training of providers.

- Better information and greater sensitivity on the part of service providers on the issue of intentions to terminate a pregnancy or doubts on this regard are to be encouraged, particularly given the extensive occurrence of sexual abuse on young women prevailing in poor sections of the population in Mexico City.
- Provide follow-up for the clients channeled to other institutions.
- Develop strategies so that the male population is included in sexual and reproductive decisions.
- Reinforce the need to establish a relationship based on trust and support with the adolescents, not blaming them for behaviors or problems they present.
- Emphasize a preventive approach to the actions developed, oriented towards improving self-esteem and autonomy in the adolescent.
- Develop systematic, continuous and lasting community work with the purpose of attracting youngsters and implementing health preventive actions with them.
- Develop, reinforce, and/or increase inter-institutional links, favoring joint efforts to deal with problems that affect adolescents.

6.3.4. In relation with physical, material and human resources:

- Guarantee the supply of all birth control methods offered at the service.
- Provide exclusive spaces and the necessary material resources, so information, education, and communication activities can be carried out.
- Promote the permanence of personnel at the service and guarantee full-time professionals with the aim of consolidating working teams.

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Appendix 1. Description of the fieldwork

A.1. Strategy for selecting the programs and attention services.

The project co-ordinator had informal interviews with people from governmental institutions, non-government organisations and multi-lateral institutions to learn about the public programs aimed at adolescent reproductive health in the D.F.

The main criteria used to select the type of programs to be studied were: a) the programs' potentiality to remain on the public agenda, b) programs that were aimed at the attention of less privileged sectors and c) that the program consisted of attention services that were specific, observable, and available for evaluation in a specific space.

Once the programs to be studied were defined, the associate researcher carried out interviews and visits to several places where the attention services were being provided, in order to select those that had adequate conditions, such as: effective functioning (not just on paper) of a team of people devoted to adolescent attention; willingness of the service staff to participate in the research project; and that the means of transportation in order to get there were easily accessible for the researchers.

Once the specific services had been selected, permission to carry out the research had to be asked from the authorities at the health centre and the hospital where these services operate, as well as from the central authorities that regulate these institutions. In order to do this, the coordinator and the associate researcher had meetings with the respective officials to explain to them the nature of the study, which had the positive effect of overcoming prior reluctances.

A.2. Interviews.

A total of 42 interviews were conducted. Three were with officials, nine with service providers and thirty with users of the services. The interviews with officials were done by the associate researcher of the project. The rest of the interviews were carried out by the associate researcher and an assistant researcher.

a) Officials. High and middle level officials were chosen who were directly related with the selected programs. Prior to the formal interview, some informal conversations had to be held with them. It was difficult to carry out some of these interviews and in one case, though there was much insistence on our part, the interview never took place because of the busy schedule of the official, who canceled on several occasions the appointments previously agreed upon. In the end, three formal interviews were undertaken. Two of them were with officials from the *"En Buen Plan"* program (one of them with an ex-official of the program) and one with an official from the PREA (see table A1).

b) Providers. Practically all the providers in direct charge of the services were interviewed; four in each of them (see tables A2 and A4), aside from a former coordinator of PREA. Their response was very good, especially at the Attention Module, where there was an excellent spirit of collaboration with the project. All the information requested was given to the researchers and space was provided where they could carry out the interviews with the users. However, the researchers had to adapt to their calendar, schedule and little time available in order to complete the interviews, which lasted from 60 to 90 minutes each.

c) Users. Thirty users were interviewed, 15 from each service (see tables A3 and A5). At the Iztapalapa Health Centre the interviews were carried out after the medical or psychological consultation, with their previous informed consent. Only on four occasions did users deny us the interview, in all cases claiming to be in a hurry.

At the Women's Hospital most of the interviews were held after the pre and post-natal lectures. In two cases the interviews were carried out in the hospitalization area, one day after the interviewee had given birth. In all cases the patients were asked for their prior informed consent. Four patients refused to be interviewed, two for reasons of time and two because the adolescents were in an altered emotional state, one because she had just found out about her pregnancy and the other because she had just told her mother about it. At this service, researchers did not have an adequate space to carry out the interviews, so they were held at the only office that PREA has, in spite of the noise and of personnel coming in and out of the room all the time.

The interviews with the users lasted an average of 45 minutes. In general there was a good disposition from the interviewees. Some difficulties were presented regarding comprehension and limitations to establish a dialog with patients with little formal schooling. The patients at PREA, which in general had a closer relation with the Hospital, showed more knowledge and experience with the service, so they talked more extensively at the interviews.

A.3. Observation and field diary.

The associate researcher and the assistant each had a field diary in which they wrote down the important information regarding the interview process (appointments, dates, things to do, etc.) and regarding the relevant aspects for the research that were registered from observation, casual conversations and informal interviews, the interaction among the interviewees (among the different service providers or between a patient and her partner, for example) and the formal and informal conversations between the service providers and the patients (courses, etc.).

A.4. Analysis.

All the interviews were taped and transcribed. The analysis was based mainly on the tabulation and classification of the answers and the adjacent discourses. A content analysis of the documents belonging to the programs selected for this research was also performed.

Table A.1

Officials

N	Program	Sex	Profession
1	*En Buen Plan* Program	Masculine	Psychologist
2	*En Buen Plan* Program [57]	Feminine	Pediatrician
3	Educational Program for Adolescents (PREA)	Masculine	Obstetrician-gynecologist

Table A.2

Iztapalapa Attention Module. Providers

N	Profession	Sex	Training to deal with adolescents	Seniority in the service
1	Psychologist	Masculine	Yes	5 years
2	Social Worker	Feminine	Yes	2 years
3	Nurse	Feminine	Yes	5 years
4	General Physician	Feminine	Yes	3 years

Table A.3

Iztapalapa Attention Module. Patients.

N	Age	Sex	Reason for consultation[58]	Place of origin*	Occupation	Schooling**	School attendance

[57] Ex - official.

[58] a = Pre-natal control
b = Birth control method
c = Psychological appointment

* Some patients come from Mexico City's metropolitan area and were not considered as migrants.

1	18	Feminine	a	Migrant	Housework	Inc. Preparatory	Not studying
2	19	Feminine	a	Native	Housework	Inc. Preparatory	Not studying
3	18	Feminine	c	Native	Student	Inc. Technical career	Studying
4	16	Feminine	a	Native	Housework	Inc. Secondary	Not studying
5	17	Feminine	a	Native	Housework	Inc. Preparatory	Not studying
6	18	Feminine	a	Migrant	Housework	Technical career	Not studying
7	18	Feminine	b	Migrant	Housework	Inc. Secondary	Not studying
8	19	Feminine	b	Native	Job	Comp. Secondary	Not studying
9	16	Masculine	c	Native	Job	Com. Secondary	Not studying
10	18	Feminine	a	Native	Job	Inc. Preparatory	Not studying
11	17	Feminine	b	Native	Student and job	Inc. Preparatory	Studying
12	15	Feminine	a	Native	Job	Inc. Secondary	Not studying
13	15	Feminine	a	Native	Housework	Inc. Elementary	Not studying
14	16	Feminine	a	Native	Housework	Inc. Technical career	Not studying
15	17	Feminine	a	Migrant	Housework	Comp. Elementary	Not studying

Table A.4

PREA. Women's Hospital. Providers.

N	Profession	Sex	Training to deal with adolescents	Seniority in the service
1	Psychologist	Feminine	Yes	5 years
2	Social Worker	Feminine	No	7 months
3	Nurse	Feminine	Yes	2 years
4	General Physician	Masculine	No	3 years
5	Nurse[59]	Feminine	Yes	3 years

Table A.5

PREA. Women's Hospital. Patients.

N	Age	Sex	Reason for consultation[60]	Place of origin**	Occupation	Schooling	School attendance

** Inc. meaning incomplete; Comp. meaning complete.

[59] First coordinator of PREA.

[60] a = Pre-natal control
b = Birth control method
c = Childbirth
d= Lecture
e= Birth control check-up
f= Infant attention

1	17	Feminine	d	Native	Housework	Comp. Secondary	Not studying
2	14	Feminine	d	Native	Housework	Inc. Secondary	Not studying
3	17	Feminine	a	Native	Housework	Inc. Secondary	Not studying
4	19	Masculine	g	Native	Student	Inc. Preparatory	Studying
5	18	Feminine	c	Native	Housework	Comp. Elementary	Not studying
6	18	Feminine	c	Native	Housework	Inc. Secondary	Not studying
7	19	Feminine	d	Native	Job	Comp. Elementary	Not studying
8	19	Feminine	c	Native	Student	Inc. Preparatory	Studying
9	19	Feminine	d	Native	Job	Comp. Secondary	Not studying
10	17	Feminine	f	Native	Job	Inc. Elementary	Not studying
11	18	Feminine	e	Migrant	Housework	Inc. Elementary	Not studying
12	19	Feminine	d	Migrant	Housework	Inc. Preparatory	Not studying
13	17	Feminine	d	Migrant	Housework	Inc. Elementary	Not studying
14	13	Feminine	d and g	Native	Housework	None	Not studying
15	19	Feminine	f	Native	Housework	Inc. Preparatory	Not studying

Appendix 2. Tables and Charts.

Table 1.1

Economic participation of adolescents

National data, 1990

Age groups	Total population %	Males %	Females %
NATIONAL			
12 to 14 years of age	(n=5,949,400)	(n=2,966,811)	(n=2,982,589)
Active	7.3	11.1	3.4
Inactive	87.1	82.8	91.4
15 to 19 years of age	(n=9,220,432)	(n=4,489,886)	(n=4,730,546)

g= Psychological consultation

* Some patients come from Mexico City's metropolitan area and were not considered as migrants.

Active Inactive	31.9 68.1	46.8 53.2	17.8 82.2
FEDERAL DISTRICT			
12 to 14 years of age Active 15 to 19 years of age Active	(n=534,362) 2.8 (n=1,242,149) 19.4		

Sources: *Los Niños en México.* INEGI, 1993b.

Los Jóvenes en México. INEGI, 1993a.

XI Censo General de Población y Vivienda 1990. INEGI, 1991.

Table 1.2

Economic activity of adolescents, divided by gender

National data, 1990

Age groups	Total population %	Males %	Females %
12 to 14 years of age	(n=418,575)	(n=320,929)	(n=97,640)
Clerk or manual worker Day-laborer or hired hand Self-employed Unpaid family job Unspecified	35.3 23.7 17.9 13.7 9.5	27.2 26.3 20.8 16.6 9	61.8 15.1 8.3 3.9 10.8
15 to 19 years of age	(n=2,943,011)	(n=2,101,723)	(n=841,288)
Clerk or manual worker Day-laborer or hired hand Self-employed Foreman or businessman Unpaid family job Unspecified	59.8 15.8 12.9 0.4 5.7 5.4	50.3 20.3 16.1 0.4 7.4 5.5	83.6 4.4 5.1 0.3 1.5 5.1

Sources: *Los Niños en México.* INEGI, 1993b.

Los Jóvenes en México. INEGI, 1993a.

XI Censo General de Población y Vivienda 1990. INEGI, 1991.

Table 1.3

Monthly salary level in populations from 12 to 14 and from 15 to 19 years of age
National data, 1990

Age group	Total population %	Males %	Females %
12 to 14 years of age	(n=418,575)	(n=320,929)	(n=97,640)
No income	24.2	29.4	7.5
Less than 1	38.9	35	52
From 1 to 2	24.7	23.4	28.9
More than 2 and less than 3	2.8	2.9	2.2
From 3 to 5	0.8	0.8	0.7
More than 5	1	1	1
15 to 19 years of age	(n=2,943,011)	(n=2,101,723)	(n=841,288)
No income	11.1	14.4	3
Less than 1	27.3	24	35.6
From 1 to 2	44.9	43.3	48.8
More than 2 and less than 3	8.3	9.3	5.9
From 3 to 5	2.3	2.6	1.6
More than 5	1.7	1.7	1.4

Sources: *Los Niños en México.* INEGI, 1993a.
Los Jóvenes en México. INEGI, 1993b.
XI Censo General de Población y Vivienda 1990. INEGI, 1991.

Table 1.4

Specific fertility rates*
National data, 1974-1996

Age group	1974 (1)	1978 (2)	1982 (2)	1986 (3)	1991 (4)	1995 (5)	1996 (6)
15 to 19 years of age	130	132	105	84	82	75	74

* Children born for every thousand women

Sources:
(1) Encuesta Mexicana de Fecundidad (Mexican Survey on Fertility), 1976.
(2) Encuesta Nacional Demográfica (National Demographic Survey), 1982.
(3) Encuesta Nacional sobre Fecundidad y Salud (National Survey on Fertility and Health), 1987.
(4) Encuesta Nacional de la Dinámica Demográfica (National Survey on Demographic Dynamics), 1992.
(5) Encuesta Nacional de Planificación Familiar (National Survey on Family Planning), 1995.
(6) Encuesta Nacional de la Dinámica Demográfica (National Survey on Demographic Dynamics), 1997.

Table 1.5

Causes of Death (Percentage)
D.F., 1998

	10 – 14 year olds		15 – 19 year olds	
	Males	Females	Males	Females
Neoplasms	36.2	48.2	26.0	33.0
Accidents	18.9	12.0	23.0	11.0
Congenital defects	7.02	6.6	1.4	4.8
Cardiovascular disease	3.7	5.4	4.1	4.8
Vascular brain disease	3.2	-	1.4	-
Acute respiratory infections	-	3.6	2.3	4.8
Maternal causes	-	-	-	8.0
AIDS	-	-	1.4	-
Other causes	35.7	28.3	48.8	36.1

Note: The data provided are presented in groups of causes according to the priorities defined by the Secretariat of Health, so there might be other important causes of death for these adolescent groups which have been included in the category of "other causes". Such is probably the case for homicides, suicides and wounds inflicted by others, which appear as important causes in other sources of information.

Source: Data provided by the *Departamento de Estadística e Informática de los Servicios de Salud Pública del Distrito Federal* (Department of Statistics and Information Technology of the Public Health Services of the Federal District), 1999.

Table 1.6

Main causes for hospital egression
D.F., 1995

	Females (n=99,777) %		Males (n=54,176) %
Complications of pregnancy, child-birth, puerperium	44.5	Traumatisms and poisonings	23.4
Tumors	7.9	Respiratory diseases	13.5
Respiratory diseases	5.7	Gastrointestinal diseases	9.3
Traumatisms and poisonings	5.6	Tumors	8.7
Genital-urinary diseases	3.7	Infectious and parasitic diseases	8.2

Source: *Daños a la Salud.* Boletín de Información, vol. 2, núm. 15, SSA, 1995.

Table 1.7.

Suicidal ideas among secondary and preparatory school students
D.F., 1991

	At least one suicidal symptom (n= 1652) %	Students in sample (n= 3,459) %
SEX		
Male	47.9	51.0
Female	52.1	49.0
AGE		
< = 13 years of age	47.4	44.6
14 years of age	18.1	15.9
15 years of age	10.8	11.9
16 years of age	8.4	9.9
17 years of age	7.4	8.6
18 years of age	3.5	4.7
> = 19 years of age	4.4	4.4

Source: López & cols. Salud Mental, 18(4), 1995.

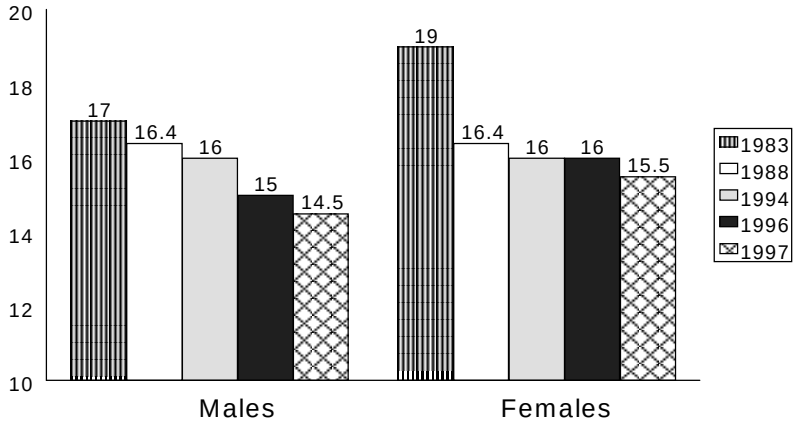
Table 1.8
Age range distribution for family violence cases in the

Centre for the Attention of Intrafamily Violence
D.F., January to September, 1997

AGE	%
From 0 to 6.	0.4
From 7 to 12.	0.9
From 13 to 17.	3.2
From 18 to 24	18.6
From 25 to 29	18.7
From 30 to 34.	18.2
From 35 to 39	15.8
From 40 to 44.	9.6
From 45 to 49.	5.5
From 50 to 54.	3.4
More than 55.	5.7
Total	100.0

Source: Gobierno del Distrito Federal, 1999, *Política Social del Gobierno del Distrito Federal. Información Estadística del Sector Social*, GDF, Secretaría de Educación, Salud y Desarrollo Social, Mexico.

Chart 1.1. Age of sexual initiation,
D.F., 1983, 1988, 1994, 1996, 1997.



Sources: Cuevas 1983; Pick 1988; Alfaro 1994; Vélez 1996; Fleiz & cols., 1998

Chart 1.2. Sexually Transmitted Diseases, D.F., 1992-93.

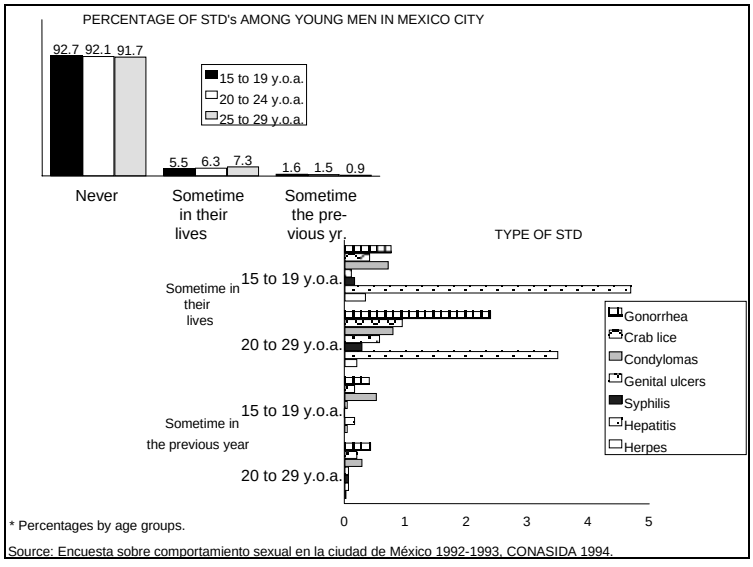


Chart 1.3. Drug addicted patients receiving attention at the *Centros de* ***Integración Juvenil,*** **D.F., 1993, 1994, 1996.**

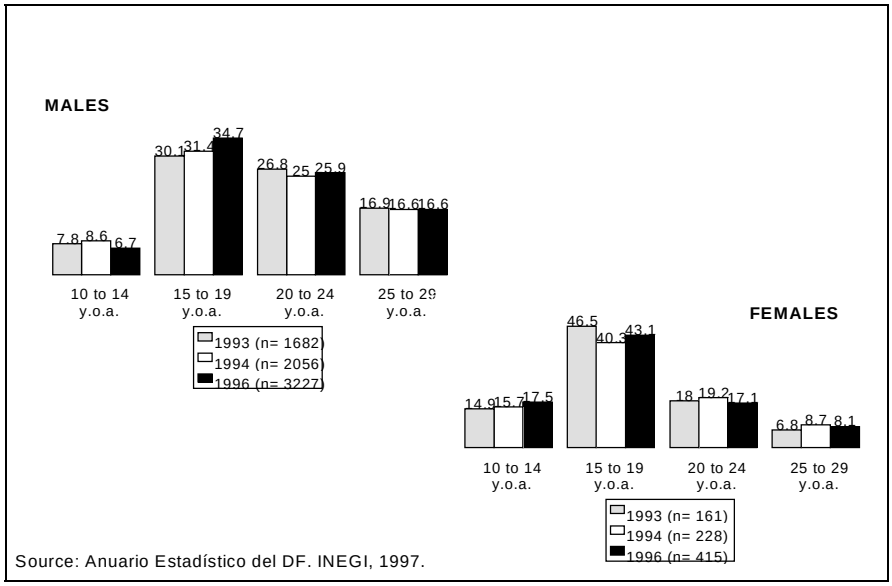
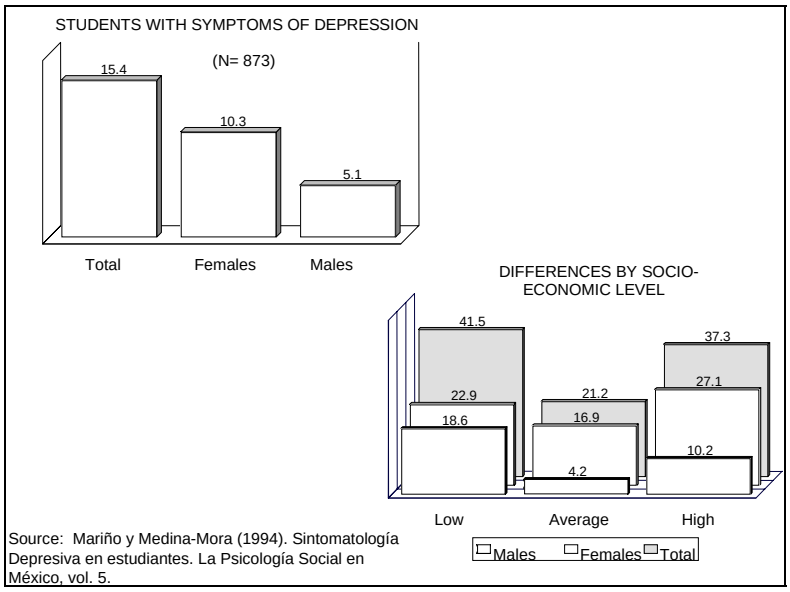


Chart 1.4. Symptoms of depression in secondary and preparatory school students, D.F., 1994.



IV. CASE STUDY

Adolescent Reproductive Health Programs in São Paulo, Brazil

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Chapter 1. Adolescent Health Care in Context

1. Formulation of programs dealing with adolescent health care: obstacles and facilitators

Health programs for adolescent care benefited from an extremely favorable political climate in Brazil at the end of the 1980's. During that period, Brazilian society was undergoing democratic change following years of political authoritarianism. The constitutional process renewed dreams of transformation, especially in sectors overseen by the government, including child and adolescent healthcare. Following the promulgation of the Constitution of 1988, the government enacted the Child and of Adolescent Law, as a result of the mobilization of the governmental and civil society around the challenges posed by these segments of the population. The problem of kids in street situations so-called street kids, present in large urban centers in general and in São Paulo in particular, contributed to the prominence attained by the child-youth question, stimulated debate and put pressure on political dynamics finding and implementing solutions. In that context, the correlation of forces was altered, giving influence to those who, even before the International Conference of Population and Development (ICPD) held in Cairo in 1994 and the Conference on Women in Beijing in 1995, highlighted the need for paying specific attention to the health of adolescents.

São Paulo, through its democratic style of governments, assumed the leadership role in this and in other areas of social policies. This democratic process, in addition to the importance of pediatricians in the medical profession, and the strength of the women's movement, were cited by those interviewed as important aspects in the development of innovative programming experiences in the São Paulo health sector, which later extended to the country as a whole. In 1983, the women's movement played a fundamental role in the creation of the Federal Program for Integral Assistance to Women's Health (PAISM). The debates on the PAISM provided an important stimulus for the proposition of a specific health program for adolescents . The notion that health actions would have to focus on women in all phases of their lives contained in the PAISM forced a reflection on the needs and rights of adolescents and young women. In addition to these discussions, the activities of non-governmental organizations regarding sex education, contributed to a state of affairs favorable to the development of health programs specifically for adolescents (Arilha & Calazans, 1998).

The debate regarding adolescent reproductive health led to proposals that confronted preconceived ideas and evoked resistance on the part of conservative

segments of Brazilian society, especially those related to the Catholic Church. Most notably, it was the presence of social actors with technical and political legitimacy and persistence in pushing the theme in academic circles, political parties, the media, and government sectors that empowered the capacity for change. The process suffered - and still suffers - from the absence of the youth as agents for the changes. There seems to be a vacuum in Brazil with regard to the mobilization and organization of youth; in fact young people are sometimes seen as interlocutors in the political debate regarding to the formulation of social policies for adolescents and youth.[61] The National Commission on Population and Development (CNPD), created after the Cairo Conference in order to follow up on the recommendations set forth by the Brazilian Government, has attempted to involve youth in he formulation of policies and programs.

For both the Adolescent Health Program and the Women's Health Program, considerable documentation (Correa; Piola; Arilha, 1999) shows that the debate in Brazil preceded the 1994 ICPD by their, the scope of social policies in Brazil were in the process of being expanded, particularly regarding the rights of citizens. The importance of sectors that had emphasized demographic objectives in health policies diminished. The ICPD brought from Brazil's viewpoint, international legitimacy to concepts under discussion internally. It is for this reason that some groups saw the ICPD notion of reproductive health as more restrictive than the Brazilian notion.

1.1 The Single Health System in Brazil

The Single Health System (SUS) today is the health care alternative for around 75% of the Brazilian population, or approximately 130 million inhabitants. The SUS was solidified in the constitutional text of 1988, which established the concept of social security as a set of actions in the field of health, welfare and social assistance. The Constitution, guarantees the universal right to health care. The principles of the SUS -- universality, equality and the integral or holistic approach – guide the provision of public health services throughout the country. Services are decentralized in the regions, hierarchical, and include social participation. However, the Constitution did not establish fixed sources of financing for carrying out the health policy, thus lack of resources has been one of the greatest constraints to maintaining and improving health care system. In spite of the difficulties it

[61] Adolescents Communication Public Durance International Seminary "Gravidez na Adolescência: Parlamentares e Especialistas Construindo Propostas para Ação". Ministério da Saúde, 13-16, August1999.

has faced, the SUS has looked for changes in the assistance model and stimulate the processes of administrative, political and budgetary decentralization, giving States and municipalities growing responsibilities for implementing their health policies. It is now up to the Federal Government to establish overall guidelines and standards for operating the SUS.

As part of the decentralization process, county, state and national health councils have been established. The councils embody the precepts of social participation defined for the SUS. Furthermore, the existence of the health councils is a basic condition for the counties to be able to receive Federal funds directly for payment of health care they provide. Health councils exist in 95% of Brazilian counties (Ministry Health, 1999).

In the State of São Paulo, 94% of its 646 counties receive some type of health resources directly from the Federal level. Although the State of São Paulo generally represents a favorable situation compared to the other states, it is worth noting that, among all the 26 state, the City of São Paulo is the only one of the 26 state capitals not equipped with any administrative arm of the SUS. Political reasons explain this difference. The Health Care Program established in the County of São Paulo, the PAS, was considered incompatible with the SUS legislation. The underlying reasons for this decision are complex and outside the scope of this document. We mentioned it simply to help the reader to locate the services discussed here. While located in the County of São Paulo, the services discussed report to the State Health Office and to the Ministry of Health. In the SUS, various modalities of health services and levels of complexity co-exist, referred to as primary, secondary and tertiary levels of care.[62] In addition to the care in the facilities already integrated to the SUS, a family health strategy is gaining increasing importance. The family health strategy, which was developed together with families in each region and which emphasizes preventive care, is expected to serve as a wedge to transform the organization of the health care system, aiming toward reversing a model that has been markedly curative in nature.

[62] In the less complex health units, basic activities are carried out, such as vaccinations, medical attention and dental care. Higher level units can offer, aside from the above care, procedures of medium complexity, including dental X-rays and electrocardiograms. At a higher level are units that are capable of radiological examinations and clinical pathology, ultrasounds, physiotherapy and polyclinics. For purposes of this study they are referred to as levels 1, 2 and 3 in complexity.

1.2 The Adolescent Health Program (PROSAD)

The Adolescent Health Program for the State of São Paulo (PROSAD) was created in 1987. Early in 1986, a group of professionals formulated the Proposal for an Integral Health Care Program for the Adolescent, the origin of PROSAD. This initiative stimulated and contributed technically toward the later development of the program on a national scale, creating PROSAD in 1989 under the context of the Ministry of Health, with the group of 10 to 19-year-olds as the target population. According to one of the officials interviewed:

> *"There is a great link between the São Paulo proposal and the Health Ministry. PROSAD made a proposal for the Adolescent Health Program of Brazil, based on the priority areas of the Program. It is extremely similar … São Paulo scarcely had the political opportunity of having begun this project before…" (Official 2, Sex: F, State Health Office).*

The activities of the Program in São Paulo served as a reference for the structuring of the services in other parts of the country. São Paulo organized training courses and received interns from all over Brazil. In March 1987, the Program was made official under State law. On the state level as well as on the federal level, the Program is supported by technical scientific committees. A goal of PROSAD is to provide

> *"inter-sector assistance, working in such a way as to identify risk factors, and stimulating comprehension of the relevance of adolescence, self-care, and positive self-image, having as a final goal transforming the adolescent into a citizen" (Official 2, Sex: F, State Health Office).*

The central objectives of PROSAD are the promotion of whole health through support of growth and development, in an attempt to reduce the adolescent death rate and to promote the individual and social adjustment. PROSAD highlights the importance of a multi-professional approach to health and the need to involve adolescents in the process. As a result, a variety of aspects are included in the Program: growth and development, sexuality, dental health, mental health, health at school, reproductive health, accident prevention, violence and abuse, culture and leisure. There is a clear recommendation that the health services should promote individual and group activities, in the Adolescents Service as well as in the community, with the thought of improving participation as a form of promoting health and health education.

PROSAD combines a biomedical approach to adolescence, the notion of holistic health and a notion of rights. An exclusively medical approach was considered insufficient to promoting the well-being of the adolescent, which was led the program toward an emphasis in the involvement of multi-professional teams in promoting health. There is a

special concern about those who find themselves in a situation of social risk, due mainly to family disorganization and precarious living conditions. Sexuality and reproductive health are priority areas for action and information is the key action in those areas. PROSAD does not make any distinction between the sexes although it includes a critical assessment of common conceptions regarding sex and gender roles. For girls, unplanned pregnancy constitutes the central problem. The documents express indicate that the authorities should not allow an adolescent girl to face the social risk of an unwanted pregnancy alone. Regarding the reproductive health of young boys, a small note indicates that this concern should be inserted into the Program, although it does not explain what this might mean.

Since its creation in the Ministry of Health in 1989, PROSAD has been associated with four technical areas, sometimes closer to women's health, sometimes associated with the program of children's health, but always with little visibility in the administrative structure. Since the beginning of 1999, the program has been part of the Office of Health Policies, defined as a Technical Area Regarding Adolescent and Juvenile Health. Its mid range objective is to produce a health policy for youth which can be implemented in the context of the most recent SUS procedures. PROSAD is receiving resources and both technical and political support, motivated in part by social and governmental sensitivity to the theme of adolescent pregnancy. Aside from this, the Program has the support of different international agencies as PAHO, UNFPA, UNESCO and ILO. However, each one of these agencies act according to with their own agendas, and there is no common agenda among them and the Ministry of Health.

In São Paulo, the Program has about 101 services, with nine of them in the capital, 92 in the interior and the coastal area. The Program has with about 745 professionals involved, taken care of around 150,000 adolescents in the last ten years.

In the meantime, management of the Program in São Paulo has been made very difficult during the last four years due to the transformations that took place under the auspices of the State Health Office itself and as a result of the restructuring of the public sector in progress in the State of São Paulo. The media has been seen as an important ally in the process of revitalizing the Program in the City of São Paulo. The decentralization of health care nourished the development of programs in the interior of the State of São Paulo. The extension of services to places in the interior of the State is a result of a concerted effort from the coordination with local professionals to re-allocate

resources already available, both financial and human resources. No special funding is being provided for that by the Government. Health professionals al local levels who identified with the objectives of PROSAD were ready to accept the orientation signaled by the central level which allowed for the development of local actions in accordance with the central PROSAD Program.

Nevertheless, the present situation of PROSAD in São Paulo is considered fragile. According to one of the officials interviewed and health providers interviewed, changes of political orientation due to changes of administration and the impact of the recent reformulation of the state apparatus place the units that provided health care specifically for adolescents in a situation of technical and political isolation.

1. 2.1 The adolescent program at the PAM Maria Zélia

The Adolescent Health Program at the Maria Zélia Medical Assistance Station was selected for this study because it has been mentioned by various key informants as one of the few services still in operation in the city of São Paulo, in spite of PROSAD'S restructuring efforts in the State.

The Maria Zélia Medical Assistance Station was inaugurated in 1985, and its first attribution was to train professionals for the new Program. Therefore, this health unit is intimately associated with the beginning of Brazilian programs for the adolescent population. Built and equipped with resources from the Federal Government, the best professionals selected from the last exams held in 1983 by the INAMPS (Instituto Nacional de Assistência Médica e Previdência Social), made up the staff of the unit. It has been later transferred to the control of the State Government of São Paulo.

The PAM Maria Zélia is a specialized outpatient clinic,[63] located in the Belenzinho district, of the East Zone of the City of São Paulo with a lower middle class profile. In the past, Belenzinho was known for the concentration of immigrants of Italian origin, however its composition has been altered due to the subsequent arrival of people from the Northeast of Brazil. By the end of 1986, a multi-professional team of clinical doctors and gynecologists, nurses, social workers and psychologists began to attend a clientele roughly ages 10 to 20. The Program[64] was halted between 1995 and 1997, because of the decreasing number of adolescents who attended the Service in general and the Program.

[63] The service could be considered to be of a complexity level 3. However, various areas are constrained by the lack of specialized professionals and appropriate materials.

In its golden years, the PAM Maria Zélia had 170 health professionals, today it has scarcely 50, due to the reduction of human and financial resources in all areas of the administration.

The Program for Adolescent Health Care at the PAM Maria Zélia was instituted in order to focus on the adolescent boy or girl in holistic manner, according to the guidelines present when PROSAD was created. Therefore, it is up to the Service to consider not only the apparent complaint submitted by the adolescent boy or girl, but also the context in which he or she is involved, beginning with his or her physical development, moving to social relationships, and performance at school or work. The descriptions made for PROSAD are valid for the Program at the PAM Maria Zélia as a whole, since, theoretically, it is subject to the common guidelines defined at the National and State level for the adolescent clientele.

1.3 The Program for Adolescent Health Care (PASA)/Samuel B. Pessoa School Health Center (CSE -- Butantã) of the University of São Paulo School of Medicine

The Samuel B. Pessoa School-Health Center (CSE) -- the School-Health Care Center of Butantã, as it is usually called – is a teaching/care unit that renders services for the State Health Office of São Paulo. Since 1977, the CSE-Butantã has been working on building models for primary health care, for purposes or research and provision of health care. The Program for Adolescent Health Care – PASA -- at this Center was chosen precisely for its mission of developing innovative initiatives of high technical quality and of offering results of studies, researches and seminars published or not for analyzing and evaluating its own services and other services in the state network of health care in the City of São Paulo.

As with the PAM Maria Zélia, the budget reduction faced by constrictions the institution have had a negative impact on the work developed, and possibly on the local epidemiological situation. However, the CSE-Butantã has some budgetary advantages, since it can obtain in its own resources, allowing for the purchase of some supplies (including contraceptives and educational material) and, more recently, the recruitment of personnel, even if on a basis contract. The CSE-Butantã handles a clientele that lives in an area delimited by the Butantã district, with some 50,000 inhabitants, including groups

[64] We are using Program when we are making references to activities defined to the adolescents which use the Health Service (Service)

who live in favelas and slums, such as some of the dwellers of the Jardim São Remo, Jardim São Domingos and others, which add up to about 11,000 people.[65]

The Butantã School-Health Care Center is today under the management of the University of São Paulo School of Medicine. In the recent past, it was under the Department of Preventive Medicine of that School. It is going through a period of transition, with the which aim to place the Service in a position to meet the various needs of the new Medical School. The Director of the Health Center should be named by a Council, which today follows the changes in progress. At present, it is too soon to know the impact these changes will have on the orientation and operation of the Health Center.

The PASA began in 1985. Until then, the Center provided only Pediatric care. Patients older than age 12 were sent to be cared for as adults. Looking for the specificity of adolescent care, the PASA adopted from the beginning a holistic approach to the individual's health care, aiming to have an impact also on community health. Following a process of evaluation and reflection (Ayres & França, 1996), in 1994 PASA established that its strategic goals would be follow-up of development and sexuality, with special attention to STDs/AIDS and pregnancy. The staff always attempted to consider the life of the adolescents as a whole, taking his or her search for health care as an opportunity to establish a dialogue, which was conceived as involving two subjects: the adolescent boy or girl and the health center.

Thus, PASA's work goes beyond specific medical care. According to the Program Coordinator, adolescents should constitute a programmatic group not only because of the biological characteristics of this phase of human development but, more importantly because of the socially vested meaning of such characteristics. In this sense, "the main theoretical concerns regarding the conception and execution of PASA have revolved around overcoming tech-political interdictions to the ethical motivation of emancipation", which means to support adolescents sexual and reproductive rights (Ayres, 1994). PASA's entire work process has been developed with an aim of "favoring the expansion of knowledge and the autonomy of the adolescent with regard to his living conditions and health." (Ayres, 1994).

With its reformulation in 1994, the Program started making an effort to attract clientele instead of handling only spontaneous demand. The Program has done so by

[65] Verification that residents live in the regional *favelas* or slums, is done in partnership with the Association of Residents in the Jardim São Remo Favela.

trying to create bridges to the community, and to create a welcome environment for adolescents. In this sense, PASA has tried to transform its entryway into what is referred to by its Coordinator as a “more unorthodox entryway” motivating young people to use the services to which they are entitled as citizens. Examples of these processes of interaction include joint activities with the extinguished State Office of Minors, in community activities, which made possible the attendance in CSE-Butantã of groups formed by the initiative of street educators. That activity generated an experimental video, used for educational purposes at the health center and by other organizations. Aside from that, activities were developed at a middle school in the region, with group discussions over issues such as STDs/AIDS, pregnancy, drugs, among other topics. Other community initiatives have included the collaboration with the neighborhood Avizinhar Project conducted by the University of São Paulo, and the assistance to the adolescents from the Casa de Passagem, a philanthropic institution which takes care of children and adolescents whose guardianship was taken away from the parents for mistreatment or who were out on the streets. These inter-institutional activities face some difficulties, given the resistance of some of the partners to comply with the orientations followed by the Program for Adolescents at the CSE-Butantã. As stated by one of the providers interviewed:

> *“They want only medical help, an appointment for dermatology, a problem with the skin … but then, something that goes deeper, to the determining factors of the problems of adolescents, are very complicated [to be accepted]. That is an obstacle” (Provider 2, Sex: M, Butantã).*

Currently, the work flow at PASA is as follows: any adolescent who arrives at the service is sent to a triage area, and a nurse assistant decides if the person should participate in an educational group, in a consultation with a general practitioner, of hear she needs a psychologist appointment (when there is some mental suffering). In the case of a suspected pregnancy, a pregnancy test is given and, in the event of a positive result, and when the pregnancy is desired, the adolescent is sent directly for pre-natal care.

Links to specialized care, including Gynecology, are quite limited in the Service. Appointments can only be made at the initiative of general clinic and are restricted to the more complex cases. A trained nursing assistant performs group activities. There are two types of group activities, each with two sessions: “Development in adolescence”, meant for younger people (ages 12 to 14) and “Sexuality, STDs/AIDS, and pregnancy”, designed for young people between 15 and 18 years old. The CSE-Butantã also develops training activities for health professionals, as trainers to professionals in the existing adolescent

services and to partnerships with non-governmental organizations that work with the contents they intend to develop (PTA, GTPOS, ECOS).

Chapter 2. Characterizing Health Services for Adolescents

2.1. Maria Zélia Medical Assistance Station (PAM Maria Zélia)

The staff of the Adolescent Health Program at the Maria Zélia Medical Assistance Station consists of two nurses, one social worker, one psychologist, two clinicians and two gynecologists. At the present time, the unit's professional staff takes care of the clientele that comes in to the Service, there being no service exclusivity in any of the Programs operating there.

In the early days of its operation, the PAM Maria Zélia took care of a poorer group of clients. Now, however, due to economic decreasing in Brazil and the resulting transformation in living conditions, it also takes care of segments of the middle class. Thus there is a huge cultural heterogeneity in the people that avail themselves of the Service. Still, among many clients, the impoverishment of the population has been noted by the professionals interviewed as a major difficulty. Many adolescent clients are feeling more pressure every day from their families to try and enter into the job market, which affects their ability to attend the Service. Forced to find a job, they lack resources for transportation to the PAM Maria Zélia and time in which to participate in the activities of the Adolescent Health Program.

Service to adolescents is provided only three days/week. The professional staff of the PAM Maria Zélia runs, literally, from one side of the Station to another, trying to handle in a few working hours a demand incompatible with the number of professionals in the unit. Staff are expected to see at least 16 patients during a period of 4 hours a day, which most of the time is not accomplished.[66] A small number of effective working hours and a great scarcity of professional staff results in a large diversity in the assistance provided, much of it in isolation, and lack of time for discussing and/or supervising the cases. For example, the coordinator of the Adolescent Health Program at the PAM Maria Zélia also works on general nursing activities, and on sterilization of items, in addition to handling the program for the elderly, among other activities. The professionals interviewed generally deplore the impossibility of dedicating more time to the adolescents, to periodic meetings and to

[66] Given the levels of remuneration, doctors in the large Brazilian urban centers divide their time among two, three or more jobs, failing to comply with their contractual hours, especially in the public sector.

working with the local community. They feel the fundamental need to regain the ability to count on specific teams for each Program, and the ability to dedicate themselves entirely to working with adolescents. A feeling of “nostalgia” emerged among the various health professionals interviewed; they reported moments of great development in the work of the PAM Maria Zélia during the decade of the 1980s, when the Service was considered an important reference in work with adolescents within public health services in the city of São Paulo.

According to the providers interviewed, the Adolescent Health Program of the PAM Maria Zélia has received, over time, indications of the positive effects of its work. In contacts with clients, they are advised that adolescents involved in the Program tend to participate more at school, have less rebellious attitudes and behavior and are more at ease with their families, and show successful professional performance. These results are also clear because of a greater ability of adolescents to follow the guidelines of the program. In spite of this, the Service regrets the lack of an evaluation of its approximate 10 years of operation, which causes uncertainty as to whether or not it is following the correct path.

The lack of financial resources and supplies means that the programs survive due to the efforts of the professional staff and not to the efforts of the central level of the responsible government department. As stated by one of the providers:

> *“If it weren’t for the personal aspect, the programs would not survive”*
> *(Provider 5, sex: M., Maria Zélia).*

Starting in January 1998, the PAM Maria Zélia underwent changes in the flow structure within the Unit, as reported in Chapter 1. With the arrival of a new health professional (pediatrician) specialized in dealing with adolescents, and fearing the cancellation of the Program due to lack of demand, the changes introduced had the goal of correcting problems in the flow of taking care of clients, which had constrained the handling of the demand. Up to that date the adolescent, upon arrival at the service, was invited to go directly to Sector 4 (Programs), at which point an interview was scheduled with the nurse coordinator of the Program, regardless of its necessity or of the reason for the visit initial. The adolescent was registered in the Program, where he or she would receive special and multi-professional attention until the age of 18, and he or she would have 12 sessions of educational activities, with various themes and activities, which

included orientation sessions on development, sexuality, STDs/AIDS, and contraception.[67] Meanwhile, in order to have the right to schedule specific consultations, the adolescent would always have to participate in the educational groups, which ended up leading to many adolescents dropping out from the Service. The changes made to streamline the process for clients have led to an increase in the number of adolescents visiting the Service.

At the PAM Maria Zélia the only contraceptive that is generally available is oral contraceptive, thanks to donations made by the pharmaceutical laboratories. The providers consider this situation, known to the central level of the state public health system, unsatisfactory. The picture at the PAM Maria Zelia is one of a general lack of supplies, from paper for prescriptions, to cards for scheduling appointments, to games and educational material, including medications in general.

2.2. Butantã School Health Center (CSEB)/PASA - Program for Adolescent Health Services

The Program for Adolescent Health Services (PASA) consists of two health practitioners -- both instructors at the School of Medicine and the School of Public Health of the University of São Paulo, respectively, one psychologist, three assistants (one of a psychologist, a teacher and a nurse´s assistant). Except for the psychologist, all the other professionals also participate in the women's health program. The women's program is older, has more resources and experience and serves as a reference for overcoming difficulties and for discussions in the context of the Program for Adolescent Health Services. PASA deals with educational groups (handled by a assistant nurse) and with medical assistance (handled by the two professionals) during only four hours per week. Doctors who form part of the women's health program (by adults) handle pre-natal and gynecological assistance and see adolescent clientele when necessary. Gynecological attention, therefore, does not provide an open door directly to the adolescent population; but only in the situations in which the client is referred by another professional.

The demand of PASA at the present time is relatively small, corresponding to about 100 adolescents/year, according to one of the providers interviewed. Nevertheless, the professionals at PASA consider this sufficient from the point of view of the possibility of creating and testing scheduling models, are sure that the clientele would grow in the event that there is a greater availability of professionals allocated to the Program.

[67] We had the opportunity to attend one of the group meetings which dealt with STD's/AIDS, and coincidentally the video shown was "Sexo e Maçanetas", produced by ECOS. It was a copy reproduced informally through interaction with professional colleagues, and not officially purchased by the institution.

PASA deplores, as do the other areas of the Butantã School Health Center, the reduction of around 25% of its employees, attributed to the cuts in specific resources that the health sector, as well as other areas of the government, have been suffering in recent years. Professionals who retire or who decide to leave the service for some reason are not replaced, and their positions are removed from the operating flow chart of the unit. The CSE-Butantã is getting around this difficulty due to its greater facility in receiving resources from other financing sources (research grants, for example) with which they can to get around the staff reductions in the unit. The activity of program coordination is, in fact, handled by one of the professionals that works for the Unit but does not have a formal contract to do this work with the Health Center. Therefore, activities that require availability of time and a consistent presence at the Service are jeopardized, making the Program vulnerable with in the institution.

Working with groups is an essential part of the philosophy of working with adolescents and, at the same time, a challenge. The greatest difficulty is the formation of groups with a sufficient number of participants. Small group sizes end up generating group situations which favor the offering of information and not situations of interaction, discussion and exchange among the adolescent participants and the assistant who is monitoring the group. As one of the providers interviewed in the CSE-Butantã puts it:

> *"We believe in the truth of groups. I think that we have to find a way to have more people in the groups, of better using this space, and then we are at a time of evaluation. What do we do? Which users should we go after, and what helpful changes do we have to make, what type of group discussions should we have to interest a greater number of adolescents?"* (Provider 1, sex: F, Butantã)

In spite of the difficulties, it is more than obvious, judging from the experiences of the group assistants, that the adolescents bond with the PASA providers, and frequently return unscheduled to talk or discuss items of interest, at times in which they need help. The Service responds, trying to show the adolescents that it is available to function as a facilitator to discuss their specific life situations. The great problem with the system is, the lack of human resources. It would be necessary to have doctors with direct and exclusive ties to the adolescent service, more nursing assistants and a social worker, to make it possible to open an interchange with the community to stimulate a potential demand which the providers believe is large.

The providers of the CSE-Butantã complain of lack of supplies for their job, including medications and contraceptive methods. Some of the contraceptives are

acquired with resources of the CSE-Butantã itself and some are supplied by the São Paulo Health Department, especially condoms and oral contraceptives. According to the information obtained, the official supply flows in an irregular manner, causing difficulties in handling client demand. From the point of view of the CSE-Butantã providers, the contraceptives are as important as the medications for chronic diseases, such as diabetes and hypertension, and they should be included in the basic list of medications offered to the population to reduce the inequalities of access to health. The CSE-Butantã providers defend alterations in the systematic method of supply from the Health Units, and suggests that contraceptives are so basic than others medicines and should be bought, is possible, by the Service as in others types of medicines.

Aside from the lack of medications, the providers say that in recent years it has been difficult get requested for exams such as urinalysis, ultrasound, urine 1 and X-rays performed outside the Service. Even the performing of HIV tests has been harmed by the lack of kits in the unit responsible for the tests.

The contraceptives generally available at the CSE-Butantã are the condom, the diaphragm and the IUD, and the oral contraceptive. The diaphragm is acquired from a national company every six months and with the Service resources. In spite of the encouragement offered for using the diaphragm, the demand is still considered to be small (2 to 3 diaphragms/month). The 386-copper-T-IUD is also acquired with its own resources, from a Brazilian company, with a demand of around 20 units/month.[68] Condoms are distributed to all users on file as “continuous users”, at the rate of 10 units/month for each user. For irreversible surgical contraception or sterilization, there is no single criteria,[69] and the hospital services, existing now are not sufficient.

In spite of all the difficulties of are not sufficient in the daily work with adolescents, and of the existing conflicts, it is worth pointing out that all the professionals showed a great deal of satisfaction in being part of PASA and its working team. They perceive in the team a great theoretic, technical and political affinity in the treatment of adolescents, despite a few differences.

Chapter 3. Adolescent Demographic and Epidemiological Profile

[68] In the case of the diaphragm as well as in the case of the IUD, the demands of the adolescent health program and the women’s health program are included.

[69] It should be pointed out that Law No. 9263 of January 12, 1996, dealing with family planning, is in effect in Brazil, which lists series of conditions under which sterilization should be performed. In the meantime, each

Because of its greater relative development, the State of São Paulo is considered to be the best equipped to offer health services to its population. As compared to other regions of the Country, residents in São Paulo are in an advantageous position in terms of the availability of health services. The SUS (Single Health System) offers 2.72 beds/1,000 population, health centers, clinics covering all medical specialties, hospitals, including high complexity care services, trained human resources (1.99 doctors/1,000 population). The City of São Paulo concentrates a large part of those resources, although other regional urban centers in the State are also well equipped.

In this chapter attention will be given to the characteristics of both mortality and morbidity among adolescents. Data from the State and from the Municipality of São Paulo are analyzed, focusing on the main health issues concerning the adolescent population. Mortality information comes from the System of Information on Mortality of the Brazilian Ministry of Health. The mortality information are based on death certificates, organized by place of residence, cause of death and age. Morbidity data comes from SUS records which have been, available since 1993. The SIH/SUS[70] contains information derived from the records of hospitals integrated to the system, which covers all hospital care provided by the public system in the State of São Paulo. There are obviously limitations to these data, since it refers to disease episodes, which have required hospital care. The data may over estimate morbidity rates, since chronic patients are counted as many times as a hospitalization has been needed.

3. 1 Socio-Demographic Characteristics

The proportion of adolescents (age 10-19) in the population of both the State and Municipality of São Paulo, remained at about 9-10% of the total population from 1980 until 1996. The volumes are impressive. They are 6,799,789 in the State São Paulo and 1,865,197 in the Municipality, according to the Population Counting of 1996.

A 1997 study conducted in the Metropolitan Area of São Paulo (which is formed by 38 Municipalities) in 1997, shows that the average per capita income of households with children between 10-14 years old a mounted to 2.64 minimum wages (about US$ 264), and the average for those with children between the ages 15-17 a mounted to 2.82 minimum wages (about US$ 282). The same survey revealed that more than 50% of the mothers of adolescents were in the labor force (55 % of mothers of children ages 10-14

service is being adapted in accordance with its own local logic, and is not necessarily obeying the rules formally set forth by law.

[70] System of Health Information of the Single Health System

and 54% with children ages 15-17). Also, 17% of households containing at least one member age 10-14 were female-headed, reaching 20% of those with at last one member age 15-17.

The Brazilian Constitution of 1998 and the Diretrizes e Bases da Educação Law of 1996 state that basic education in Brazil should be public, and free for the 1st to the 8th series. The reality is far different. Nevertheless, the State of São Paulo has the best education record in the Country. In 1996 (PNAD 96), 95% of adolescents ages 10-14 in the State of São Paulo were at school, while 64% of those ages 15-19 were enrolled. In the Municipality of São Paulo, the Census of 1996 revealed that 95% of children ages 10-14 and 65% of those ages 15-19 were enrolled in school. However, some of them were delayed in the formal education process. A survey in the Metropolitan Area of São Paulo in 1997 showed that 24% of those ages 10-14 and 31% of those ages 15-17 were delayed when comparing age and school series.

3. 2 Mortality

The health problems of adolescents differ from those of any other age group, a fact that holds for any geographic area in the country.

Mortality rates[71] for adolescents differ according to whether they are for the City or for the State of São Paulo or for children ages 10-14 compared to ages 15-19 (Table 1 from the ADDENDUM 1). The first difference is that in the City, males ages 15-19 have a mortality rate 18% higher than in the State, while for females the rates are nearly equal. The 10-14 year age group shows a 14% reduction in mortality from 1980 to 94 (more marked among the males), while the mortality rate for those ages 15-19 showed an increase of 32% (with a 37% increase for males and a 4% increases for females). Another difference is that adolescent males showed much high mortality rates compared with females. In the 10-14 age group in 1994, the difference between the sexes was approximately 40% in both in the city and in statewide groups. In the 15-19 age group, the biggest difference was in the State (with male mortality 70% greater than female mortality, while in the city the difference was 61%.

In 1997, external causes contributed to the greatest share of adolescent deaths in the city of São Paulo, making up for 75% of the increase in the total rate (and 83% among males). These findings hold for both age groups, with the average increasing as age rises

[71] To avoid possible annual fluctuations, calculation of mortality rates by sex and age is based on the average of deaths corresponding to the years 1979-81 and 1993-95.

(Graph I from ADDENDUM 1). Thus, while this large group of causes represented 63% of deaths among male ages10-14, it represented 87% of deaths for male ages 15-19. Among females the trends are similar - external causes were linked to 48% of the total deaths; 40% of deaths in the 10-14 age group and 52% in the 15-19 age group were classified as external causes. Among these causes, accidents and homicides, especially among young people ages 15-19 (with a percent increase of 51%), grew the most from 1980 through the mid - 1990's. Cancer is the second greatest cause of death (particularly leukemia and brain cancer), except in women ages 15-19, where it occupied third place, following disorders of the circulatory system.

After the second position, there is a change in the structure of causes of death as a function of age. Among adolescents ages 10-14, respiratory diseases (most frequently pneumonia) occupied the third place, followed, in order of importance, by parasitic infections and those of the nervous system (especially cerebral paralysis) for both sexes. Among males ages 15-19, with nearly the same relative values, the most significant causes of death are diseases of the nervous, circulatory and respiratory systems. Among females causes of death which stand out are those related to circulation (especially cardiopathies), neoplasm, respiratory diseases and, in the fifth place, parasitic infections, which are showing a reduced prevalence as a result of improved basic sanitation in the City of São Paulo.

The death registries for the City of São Paulo in 1997 showed that, among all infectious and parasitic diseases (Table 2 of ADDENDUM 1) AIDS caused the greatest proportion of deaths among adolescents ages 10-19, representing 25% of the total deaths. Following was tuberculosis with 23% and septicemia with 9%. However, this picture changes when the population is separated into five year age groups and by sex. In the 10-14 year age group, tuberculosis is the most common cause of death, especially among females (50%); and in the 15-19 year group, AIDS is most frequent, especially among women.

Brazil stands out in terms of its number of reported cases of AIDS; it is highest in all of Latin America and among the top three worldwide. Records of AIDS begin with the first report in the City of São Paulo in 1980. Presently, the State of São Paulo has the largest concentration of cases nationally (57%), with a cumulative incidence rate of 94.8 cases per 100.000 inhabitants, with a rate of 0.4 in the 10-14 year age group and 3.0 in the 15-19 year age group. The prevalence rate for these same age groups in 1996 was 1.7 for these age 10-14 and 13.0 among young people aged 15-19.

HIV and AIDS are increasing among females statewide. While in 1985 the ratio of men/women with HIV was 35/1, there has been a substantial shift, with the ratio currently at

2/1. Furthermore, while notable fact is that, HIV cases are still concentrated in the 20-39 age group, people are being infected much younger. HIV infected young people ages 10-14 represent 3.3% of the total AIDS cases.

In the case of São Paulo, heterosexual transmission with a fixed partner who is drug user has become the primary risk factor among women and is the main target of prevention programs and campaigns which emphasize safe sex. Among the male population, “the user of intravenous drugs, together with heterosexual transmission, are the categories which are assuming growing importance in the epidemic’s dynamics” (Barbosa, 1996).

3.3 - Morbidity

In analyzing the morbidity among adolescents living in the City of São Paulo in 1998 several differences are evident based on sex and age group. Among males (see Table 3 in ADDENDUM 1) the violent causes, most notably lesions and poisoning are the most prevalent reasons for hospitalization. The second cause of morbidity is concentrated on the diseases of the digestive tract although age-specific differences are striking. Adolescents 10-14 ages are hospitalized with greater frequency for disorders of the genital-urinary and respiratory systems, then for neoplasm. Adolescents ages 15-19, a relatively high percentage are hospitalized for mental and behavioral issues, with a relative weight of 7% of all causes, and representing 55% of all hospitalizations for these causes, The explanation for this high percentage could related to the need for hospitalization for treatment for chemical dependency.

Among females, only the proportional morbidity for problems of pregnancy, birth and postpartum care are similar between the two age groups, occupying first place. In adolescents ages 15-19, these causes represent 78% of all hospital stays. Due to the high percentage these causes show in the total of hospitalizations, the next four most important reasons show values which vary from 3% to 2%. They are disorders of the genital-urinary and digestive systems, neoplasm and respiratory disorders. In adolescents ages 10-14, the illnesses that prevail, in order of importance, are respiratory disorders (11%), external causes (9%) and neoplasm (7%).

Specific data on AIDS (Tables 4 to 7 in ADDENDUM 1) shows that out of a total of 97 hospitalizations in 1998, 70% were males and 72% were concentrated in the 10-14 age group; showing that this group is the most affected by perinatal contamination. Within the 15-19 age group, 78% of the AIDS hospitalizations were males.

3.4 – Pregnancy in Adolescence

Data recently published by Family Health International based on the results of a 1996 study of Brazilian women ages 15-19, published in the book Seminar on Adolescent Pregnancy, concluded that, in this country, one in ten woman age 15-19 already had two children, estimating that each year 1 million adolescents ages 10-19 give birth, which corresponds to 26% of all live births. 50% of these women had the child before the age of 16, and in 50% of the cases, the birth was not planned.

In the case of the State of São Paulo in 1997, 140,000 children of mothers under 20 years of age were registered, representing 20% of all births, a higher percentage than that of the City of São Paulo, in which children to mothers under age 20 represented 17% of the total (SEADE, 1998).

The National Demography and Health Survey -- PNDS (BENFAM, 1996), offers information on adolescent reproductive health in the State of São Paulo. The PNDS showed that 100% of the adolescents ages 15-19 know modern contraceptive methods. However, despite the high degree of knowledge, the contraceptive use is very low in these age groups. Fully 83% of young women and 34% of young men said they had never used any method. Among those who did use some form of contraception, 62% of the males and only 15% of the females used methods considered modern (Table 8 of ADDENDUM 1). With this picture in mind, it is possible to understand the incidence of unplanned pregnancy and the need to resort to abortion. In 1997 complications of abortion represented 7% of deaths referred to as resulting from complications of pregnancy, birth or postpartum (Table 9 of ADDENDUM 1).

Of all the adolescents ages 15-19 interviewed in the PNDS, 18% had already been pregnant and 14% were already mothers (Table 10 of ADDENDUM 1). Prenatal care is among the factors recognized as potentially able to reduce the risks that contribute to maternal and child morbidity. Approximately 80% of those interviewed had their first pre-natal consultation during the first trimester of pregnancy, and the majority of them made more than seven visits to the doctor during the course of pregnancy.

Although there is a decreasing trend in maternal mortality rates, the average in Brazil is about 120 deaths per 100,000 live births, a level considered high compared with other countries of the same level of development. SEADE (1998) estimates a level of 42 deaths per 100,000 live births among women 15-19, noting however that this may represent under-reporting for this age group. Of deaths among females in this age group in 1997, 5% were attributed to causes linked to pregnancy, birth or postpartum. Eclampsia, together with hypertension related to pregnancy and illnesses of the mother which are complicated by

pregnancy (with respiratory and circulatory disorders being most common), are the principal causes of maternal death during this period. Combined they accounted for 67% of all maternal deaths in adolescents ages 15-19 in the City of São Paulo in 1997.

There is no consensus on the implications of pregnancy among very young women with respect to the health of adolescents themselves. However, available information show that the incidence of low birth weight is higher in children born to adolescent mothers, a result attributed to a higher rate of anemia. Data indicate that some 17% of babies born to mothers ages 10-14 years and 11% born to mothers ages 15-19 weighted less than 2,500 grams. (Table 11 in ADENDDUM 1)

Natimortality and infant-mortality rates also provide evidence on the effects of a too early pregnancy (Table 12 in ADDENDUM 1). Estimations for the City of São Paulo show that natimortality rates decrease as age of the mother increases, representing 13/1,000 live births among mothers ages 10-14 and 11/1,000 among those between ages 15-19. Infant mortality among children born to mothers ages 10-14 is 50% greater than among children born from mothers ages 15-19.

3.5 – Drug Consumption

Consumption of alcohol is becoming increasing problem, now reaching 3-10% of the Brazilian population. Alcohol dependency is 7 times greater among males than females. National statistics are lacking, making it necessary to resort on data provided by small studies. A study of Brazilian students in 1989 revealed that, of a total of 47,000 public and private school students interviewed, 3.5% considered themselves frequent users of some type of drug, having used it at least six times in the previous 30 days. The study showed significant homogeneity in drug use. The author says: “Excluding alcohol (47%) and tobacco (27%), the most-used drugs were solvents and inhalants (17%), anxiolytics (7%), amphetamines and anorexigenics (1.5%), marijuana (3.5%) and barbiturates (2%)” (Takiuti, 1997).

Records from the State of São Paulo’s Adolescent Health Program – PROSAD--showed that, since the implementation of the Program, 8% of all the Service’s attendees had some type of involvement with drugs, totaling 93,000 adolescents of 35% were female. With frequency of drug use as a criterion for classification, the Program’s information showed that 40% of the total were characterized as drug dependent, those who could not perform their daily functions without the help of some psychoactive substance (Takiuti, 1997).

3.6 – Final Comments

The availability of health-care services and specifically those geared towards the adolescent population is better in the State of São Paulo and the Capital City than in the rest of the country.

Nevertheless, while mortality rates for the City's population ages 10-14 from 17% to 12% between 1980 and 1991, the mortality rate for males ages 15-19 grew considerably (37%), unlike in most other age groups. This phenomenon is due primarily to the growth in deaths due to violent causes in that age group. Even recognizing the complexity of this group of causes, their underlying determinations go beyond the health issues, thus deaths due to external causes can still be considered as avoidable deaths. It is a responsibility of those in charge of social policies to implement specific preventive actions able to produce a reversal of this trend.

Of all deaths of adolescents ages 15-19 in 1997, causes related to complications of pregnancy, birth and postpartum represented 5%, with the most frequent being Eclampsia and hypertensive disorders. Precocious pregnancy increases the potential for low birth weight, which affects the neonatal and infant mortality rates as well.

Finally, a significant percentage of adolescents find themselves involved with drug use and nearly one-half of these will, by their own admission, be considered addicted to chemicals.

Chapter 4. Adolescent Health from the Providers' Perspective

4.1 - The integral approach to health care

The integral, holistic approach, along with equitable access to universal health care, are the building blocks of the SUS and, therefore, should preside over all public health care in Brazil. Nevertheless, the concept of the integral, holistic approach has been interpreted in various ways. As one of the providers interviewed at the CSE-Butantã well remembers, the idea of programs was widely disseminated in Brazil during the decade of the 1980s, almost always containing in its names the word *integral*.

An important example is that of the PAISM - Program for Integral Assistance to Women's Health, which served as a model for various other programs that followed. However, even in the PAISM field of action, the implementation experiments have required reflection and continuous attention on the part of researchers and health professionals on

the nature of the principle of the integral approach and its translation in operational terms. Schraiber (1999:19) states that the “integral approach is not summarized (…) into an inter-disciplinary matter, and this is not the same thing as team work, which should include inter-professional communication.” The type of approach in the principle of the integral approach is indicative, among other aspects, of the form of organization, structure and function of the Services.

Thus, the “vision of the uniqueness of care from the patient’s perspective is not confused with the impoverished and distorted notion of the integral approach when an excessive fragmentation of attention is prescribed by the multiple interventions of different professionals and health workers for the same patient (physician, nurse, psychologist, assistant social worker, occupational therapist and others, to which are still added the respective technicians and assistants)” (Ministry of Health, 1999). Against this type of fragmented organization working on health care, is the attempt to see the patient as a whole, tackling his or her problems by starting with an overall listening effort, with the minimum of necessary professional intervention. “That form of Service organization identifies the patient’s needs and tries to offer him the appropriate resources to take care of them, instead of insisting on the idea that for each need there would be a specific action and/or special professional to meet it” (Ministry of Health, 1999).

The Services studied are indicative of various forms of the integral approach. At the PAM Maria Zélia, for instance, added weight is given to the presence of various professionals who, starting from different viewpoints, meet the different needs of adolescent care.

At the Butantã School Health Center there is a collective intent to break away from the interpretation of the integral approach concept which considers the subject as an isolated individual, enclosed within his individual reality. In the case of the adolescent, this approach tends to have a pre-conceived notion of what a “normal adolescence” should be. This approach also highlights the dispute between the fields of Pediatrics and Gynecology by regarding the approach health questions of the adolescent boy and girl. It is not by chance that the word “integral” is absent from the title of the CSE-Butantã Program, the PASA. This absence stems from the fact that the professionals responsible for PASA do not believe in a social welfare model according to which the integral approach to care would be assured by the multiplicity of specialized views on the adolescent. From this stems the nonexistence, in Butantã, of the usual routine in the Services for adolescents in

which the user goes through various specialists. As put by one of the providers interviewed in that Health Center,

> *"The integral approach for us is nothing more than the composition of a team to which there are various entries. Work on the integral approach is started much before that of assistance … it is necessary to sit down and have each one bring his contribution ... For example, knowing what the doctors say when they talk about a change in the body, what the social scientists say when they talk about body change … the integral approach was being replaced by medical assistance, and the doctor is the great "dispatcher". He "dispatches" to the assistant social worker, he "dispatches" to the psychologist when there is nothing that needs to be looked at by the doctor…" (Provider 2, Sex: M, Butantã)*

Aside from the aspects cited, it is important to highlight the social emphasis of the providers' approach, which belongs most effectively to the team of the CSEB adolescent program. The nucleus of the team maintains the point of view that the integral approach must be understood as the possibility of perceiving the user of the service within his living conditions, as a subject inserted in a specific social-political-cultural context, which conditions his choices. It is starting with the context of the subject's life that one looks for the possibilities of interaction focusing on health care. One of the interviewees expressed it this way:

> *"I think that the idea of the integral approach had to be that of the whole person, such as a person complete with history, with likes, …and to place that within something more in the aggregate, historic, regarding the place where people live. And it doesn't help to make a speech to an adolescent from the lower class, which is the same as a speech to a boy who is here at the faculty, here in the USP. And with sexual and reproductive health it's the same thing…" (Provider 3, Sex: F, Butantã).*

The perspective of the integral approach gains a different vision from the voice of a provider who handles specialized gynecological care, referred to in the service, reinforcing the tendency toward the nonexistence of a unique concept of the integral approach, much less a unique service. Contrary to the majority of the providers interviewed at the CSE-Butantã, its tendency is to consider that the greatest benefit than can be offered to the user would be to provide efficient health care, bearing in mind the context of the patient's life. Also recalled by one of the providers interviewed was that health is, initially, a responsibility of the subject himself, making him understand his active responsibility to take care of himself,

> *"… the service depends on the way the individual lives, on what the individual's option for living is and for using his own body and expending his own body, his options, his social contingencies…" (Provider 5, Sex: M, Butantã).*

In that context of the job, in which the principle of the integral approach has a great theoretical, technical and political centrality, the concepts of sexual health and reproductive health are understood in a limited way, especially the concept of sexual health. To limit sexuality to sexual health is seen as restricting the right of the user of the service to exercise his sexuality in the most free and pluralistic manner possible. It would be up to the provider to respect the experiences chosen by people. The concept of

reproductive health would have in its favor the possibility of making the service sensitive to considering aspects other than those that relate exclusively to pathologies. For example, the conditions of choice or the decision to have children or when to have them.

Health professionals at the CSE-Butantã are extremely critical of the notion of risk which permeates the concepts of sexual health and reproductive health. The notion of vulnerability tends to take the place of the idea of risk.[72] The notion of risk carries within it the idea of the possible occurrence of an injury or an illness, considered undesirable and as the product of behaviors also considered undesirable. Damage control involves control over the behavior that caused it. If there is a risk or a chance that a specific injury or illness might occur, there are risk factors, that is, factors that would favor their appearance in a defined population group. The theme of adolescent pregnancy is an example in the criticism of the risk concept. Risky behavior would be premature sex without contraceptive protection. In Brazil, it can be stated that there is a greater probability of pregnancies occurring among young women as 15 to 19 with barely one year of schooling. Emphasis on vulnerability focuses the vision on the conditions that lead adolescents to becoming pregnant, failing to restrict the attention on only the reasons for which adolescents fail to use contraception and, consequently, becoming pregnant.

At the PAM Maria Zélia, both the concept of sexual health, and the concept of reproductive health are translated as the conscience of the body itself, of sexuality itself: to have or to look for leading a healthy sex life, free of diseases, to be able to have children without worrying about STDs, to be able to plan when and how to have them, and to have pleasure. Among the providers at the PAM Maria Zélia, some show more sensitivity to gender differences. Gender differences are identified in the building of the subjective identity of boys and girls attended to by the Service, in the family dynamics of the clientele, which is especially manifested in the frequent overloading of the girls with the domestic duties. Gender differences also manifest themselves in participation in groups, which are composed of both boys and girls. The boys tend to be more restrained and to participate less, and exhibit more difficulties in creating friendly relationships which favor their participation and continuity in the groups. In the words of one of the providers:

> *"…they are very closed, always responding that everything is fine, it's very difficult to find somebody who says everything is not fine … normally they only say [that something is not going well] when it's in the physical area, say, in the penis, a difficulty with erection, but in general it's a real mystery … It's the mothers who talk about the problems they're having, [but the reference] is organic also: "He is having difficulty in urinating, for instance … We don't ignore organic changes, but problems in the sexual sphere go by the wayside because they don't open up…" (Provider 1, Sex: F, Maria Zélia).*

[72] The Program Coordinator at the Butantã School Health Center has been one of the defenders of the idea of vulnerability as opposed to the notion of risk, bringing it into the theoretical, technical and political discussions within the sphere of sexuality, reproductive health, sexual rights, reproductive rights and human rights. The idea of vulnerability has widened the possibility of comprehending the social conditions that affect the emerging of health problems in specific groups, with implications for the formulation and execution of public policies in the health field.

In the Butantã School Health Center, staff have begun to acknowledge the importance of gender differences. In a visit to the CSE-Butantã, we heard a provider say*: "we are recently starting to look at gender". At* the CSE-Butantã, attention to gender goes further than looking at the clientele; staff are trying to see how gender affects at the characteristics of the Service.

The professionals have startet to question the reasons for the difficulties in attracting a young men to the service. They think that in the Service itself may be immersed in a cultural configuration that defines it as a feminine place, with care for women only, making it difficult to attract young boys and adult men. The providers acknowledge the difficulty in modifying this feminine structure in practice. How is this "feminine face" manifested in the health services? That is a question that one of the providers asked himself, inquiring as to what would be the actual possibilities of transforming the service. One of the providers noted that, in the CSE-Butantã as well as in the public health service in general, most personnel dedicated to providing care are women. Aside from that, staff noted a tendency of the employees to develop a strong identification with the female clientele, reinforcing their autonomy and thereby collaborating in constructing the image of the men as " antiquated and retrograde". The service currently attempting to overcome the exclusion of boys and adult men especially with regard to their reproductive lives. For examples they are trying to include men in contraception care and pre-natal follow-up are.

At any rate, attention is called to the fact that the perspective of gender is not unknown among the Service providers, influencing its conceptions regarding the role of care-taking as performed in the public health system. Almost unanimously, providers see as the responsibility of the health service promoting self-esteem and the autonomy of the users. Virtually all of the providers interviewed in each one of the services believes that the health services has a important role to play in the development of a social conscience and rights among the users. Uniformity in the responses regarding a woman's right to regulate her own fertility, as well as her right to decide about contraceptive use, regardless of her partner's opinion, shows that these professionals are exposed to debates and reflections in the field of reproductive rights, an area in which, as a matter of fact, Brazil has advanced a great deal, as mentioned in the first chapter. Respect for freedom of choice by the woman regarding abortion in the great majority of the interviews with providers and with top level employees shows this impact.

4.2 - Sexuality and Pregnancy in Adolescence

Providers both services start with the assumption that adolescents of both sexes have an active sex life nowadays. The approach to sexuality, however, differs greatly in the Services analyzed.

At the PAM Maria Zélia the preoccupation is more toward the prevention of pregnancy and of STDs/AIDS. With the sex life being a fact, avoiding the undesirable becomes the major motive for education and action. In this view girls have sexual relations without pleasure and boys have little responsibility when faced with the possible consequences of their sex life. Discussion during medical consultations or during educational activities about sexual pleasure is still incipient at the PAM Maria Zélia.

The daily preoccupation in health care at PAM Maria Zelia is that of supplying subsidies so that adolescent boys and girls can prevent STDs/AIDS and unwanted pregnancy, the first step of which would be to have a more affectionate context for sexuality. To offer empathy and support so that the adolescents have a place in which to relate their sexual experiences seems to be foundation of impel the work there. Given the lacking the of emotional and psychological support on the part of the family, PAM offers itself as a place where information and support in the field of reproduction are available. There is an ambiguity here, since they neglect the pleasure as an individual's right or as a citizen's right, and question whether the school would not be the most appropriate institution for promoting discussions of that nature. The professionals at Maria Zélia speak and act starting from their own theoretical and personal preconceived ideas regarding the problems of adolescence. Although staff are sensitive listeners, that does not seem to be sufficient to promote critical reflection, much less systematic actions to eventually alter the direction of daily practice.

At the CSE-Butantã, the conception of PASA itself defined sexuality as the component for strategic actions toward building healthy citizens of young people. Thus, as spoken by one of the employees,

> *"The second axis, the question of sexuality in our perspective was a very important phase … it considered that the school health center should give support so that this dimension of existence that was beginning to be more intense in that phase might be more pleasurable, and as free as possible. Also, there was another area that we also would discuss, which was the question of pregnancy. For us, from the beginning of this X-ray map that we made, nothing convinced me that adolescent pregnancy was a question of risk, like a question that the adolescents were irresponsible. Some spoke also about emotional immaturity and what I saw as a bias toward having a social risk associated with adolescence … and not a biological risk…" (Employee 4, Sex: M.)*

In that way, the Adolescent Service of the CSE-Butantã took the opportunity for communication on sexuality, unconnected to the occurrence of a pregnancy. CSE-Butantã providers view theme in various ways. The team is not unanimous regarding the question of pregnancy in adolescence. Some professionals think that pregnancy is not necessarily a negative episode in the life of the adolescent or young girl, while others think that the birth of a child can make the girl's scholastic and professional development more difficult. In the view of the providers, the relevance of the pregnancy would have to be viewed in light of the importance the adolescent, particularly these from the lower classes would have given to scholastic achievement:

> *"The impression given is that education does not seem like something that is an alternative which can give more options. In this sense they [adolescent girls with low incomes] are opting for abandoning a certain type of course that does not seem promising to them and [opting] for another one that seems more promising, at least from the affective point of view. They will have someone to take care of and will be able to have an intense affectionate interchange with that child. Sometimes this is a project for the couple and at other times it is a more individual project for the girl" (Provider 1, Sex: F, Butantã).*

Contrary to that of Maria Zélia, the Butantã work style is to support the decision of the adolescent boy or girl, no matter what it might be, and to avoid speeches that deny the importance of the desire to become pregnant or that question whether that plan is wise or unwise. Such a position allows, in daily practice, the construction of a space at the health service that can promote the development of an awareness of rights. Even then, the Service still considers itself insufficiently prepared to support adolescent girls who live with an ambiguity in their desire for pregnancy and for the child. Thus difficulty can give rise to offer results in the personal perceptions and opinions of the providers influencing the decisions of the adolescent girls regarding their pregnancies.

The approach of PASA/CSE-Butantã involves not equating adolescent girls will adult woman. The providers thus emphasize the need to have different groups of pregnant clients - one for adolescents and one for adult women - as they clients tend to establish themselves within mixed groups in a power-based hierarchy determined by age.

4.3 - Abortion

In accordance with the Penal Code of 1940, abortion is illegal in Brazil, except in cases where it is life threatening to the mother or in which the pregnancy is a consequence of rape. Even in those cases, it was only in the last 10 years that, under pressure from the feminist movement, the State began to offer care in some public services.[73] as indicated by the legislation, abortion is a complex issue in Brazil, moral and religious. Promoting the termination of unwanted pregnancy among adolescents is not part of the daily practice of

[73] At present 16 legal abortion services operate in different capital cities in Brazil, in spite of the strong opposition by the Catholic Church.

the Maria Zélia providers, in spite of this being a specialized outpatient clinic. Adolescents are not presented with abortion as a viable option and thus they are not able to take effective stands with regard to heeding the option. To the contrary, we heard stories of interference in the direction of actively suggesting to the adolescent that she not undergo an abortion, alleging that she could be submitting herself to risks by using a clandestine clinic that would be of low quality.

> *"… thank God we managed to make her change her mind…we showed her the consequences of looking for a service that wasn't compatible with her socio-economic conditions…then we managed to make her see the other side, afterwards she started the pre-natal care and had the child…"(Provider 1, Sex: F, Maria Zélia).*

Butantã resolved to face the challenge of offering solid alternatives with regard to the decision on the part of the adolescent girls and adult women to have an abortion. For that purpose it created the possibility of immediate access for a pregnancy test, even without a scheduled appointment. In the event of a positive result, and the presence of a reaction of doubt or dissatisfaction, with the positive pregnancy test no pre-natal consultation is scheduled. The client can return for a later consultation at which time she can more clearly define her options.

> *"…to us the idea is to respect whether the person wants it or not, and to be there to help her in whatever she decides, no matter what the decision might be, to have the baby or not to have it …we help her to avoid getting sick because of this". (Provider 3, Sex: F, Butantã).*

The service does not spell out the alternatives for a later abortion, for example recourse to CYTOTEC, and it does not make any kind of institutional referral. However, it does place itself at the ready to take care of adolescents and adult women in the event that there is a later need, for example of there are post-abortion complications. In the case of the adolescent girls, the Service does not communicate with the parents or with the family, even knowing that abortion is illegal of and the clandestine manner of most abortions. Providers interviewed feel that adolescents face greater difficulty than adult women to choose abortion: they are more frightened, and they handle with more difficulty the few options placed before them regarding this matter. The absence of financial resources, of family conditions, of general information can make the road to maternity even more difficult and distressing than it might seem, making abortion seen more feasible. The Service at Butantã refuses to place itself between the adolescent and her decision, as contrasted with the PAM Maria Zélia, whose stance is clearly pro-maternity. To the contrary, it tries to actively offer the adolescent an environment to make her own reflection and choice. As put by one of the providers, it doesn't do to say that the Service

does not judge the adolescent girl or the adult woman, if it doesn't offer alternatives within the service itself for a free choice.

4.4 - Contraception and parental authorization

The right of adolescent boys and girls to sexuality and assistance with contraception without significant moral or religious constraints is recognized in both Services. Contraception for adolescents is understood as a right, and it is presented as such in discussion groups and in medical consultations held in both the services. However, the depth of the discussions and the capacity for effective action in the area of contraceptive use are very different between the Services.

At the PAM Maria Zélia contraception is almost always restricted to information due to shortages of condoms, IUDs, diaphragms and contraceptive pills. In the CSE- Butantã, the demand for contraception is treated as an important part of adolescent life. As with other aspects of sexuality, contraception is approached as a powerful tool to help build adolescents into citizens that the Adolescent Program tries to stimulate. At the CSE-Butantã, this theme is addressed in the educational groups, and is also approached actively by the doctors during consultations. Consistent with the CSE-Butantã conception of health care, the adolescent can join the educational groups directly, without being referred by a medical professional.

Both Services try to direct adolescent boys and girls toward the use of methods that preserve of health, autonomy and AIDS. In the case of the CSE- Butantã, patients are directed toward the IUD, diaphragm, condom, female condom and only in some situations toward oral contraceptives. (if the adolescent has been menstruating for at least three years).

Neither of the two Services inform parents informed about the use of contraceptives by adolescents, and no type of authorization is requested. This point was stressed by one of the providers at the CSE Butantã:

> *"we don't take any kind of precaution, not because we're careless, it's a stance. In a certain sense it subverts the order, but we think that if we interject ourselves in that relationship with the adolescent who comes in spontaneously to look for some kind of help, who comes in to solve a problem he or she is going through and which is important to his or her life, we are going to scare… Because that adolescent comes in looking for us precisely because it's something he's not going to go to the family about and all the restrictions that it (the family) puts up and that maybe we don't even know about… probably the time of adolescence is the phase in which the individual tries to assert himself and doesn't entirely succeed, but he makes a move, shows a type of withdrawal from the nuclear family to which he belongs; then, it would be*

extremely disastrous if one asked for authorization…" (Provider 2, Sex: M, Butantã)

As stated by another provider at the CSE-Butantã

"it's a matter of developing a kind of civil resistance … which puts the adolescent at center stage, he is the star…" (Provider 2, Sex M, Butantã)

The availability of contraceptive methods in the service often dictates what method is recommended. As mentioned previously, the CSE Butantã has the capability to obtain by direct purchase or from donations the condom, the diaphragm and the IUD either by direct purchase or from donations made as a function of the institution's involvement of in research. The PAM Maria Zélia, meanwhile does not have available any type of contraceptives, except those that are donated. The PAM Maria Zélia has less operational flexibility in providing supplies, being more dependent on donations of methods on the part of the pharmaceutical laboratories, which influence the method recommended by the Service. As stated by one of the providers interviewed:

"IUD, a long time back the public health sector didn't see the IUD, then restrictions really existed for use by adolescents, all that remains for us is the oral and injectable contraceptive" (Provider 5, Sex: M, Maria Zélia).

Thinking about the family context, providers also consider the case of secrecy the contraception allows when recommending methods. Aside from availability and secrecy, technical appropriateness, and the choice of the patient are criteria that define the contraceptive recommended.

4.5 - Violence

For about five years violence has become an integral factor is the work of the CSE-Butantã.[74] The Adolescent Service has learned from the experience of the women's health program, developed at the institution.[75] Activities for preventing and combating violence developed recently indicate, at the same time, the decision to know the local community more deeply and to establish ties with other institutions in order to support the actions of the Health Center. Facing the violence problem reveals, according to providers interviewed, a process of maturing at the Service, but seldom addressed in the work.

The introduction of that discussion in the Health Unit provoked changes in the tools developed by PASA, allowing providers' to approach the users who suffer or suffered from some type of violence. Thus, as put by one of the providers,

"we changed the question about violence that we wanted to investigate, since it was an important question among the adolescents. We put the question in the portion of the private medical interview … it was a more intimate matter,

[74] Incorporation of the theme of violence was quite evident when in one of the visits made to the service we had the opportunity of seeing collages displayed on the wall, developed in discussions in the waiting rooms with all the users of the service.

[75] One of the providers interviewed in this Program has a scholarship from the MacArthur Foundation and with this recourse is working in the service in order to give visibility to the problem of violence among the users of the service and, at the same time, to reflect and act upon forms of institutional violence, including the violence that the service itself exercises over the users.

> *and we thought it would just stay there if nothing came of it. In the group it gives the impression of mutual reinforcement and one talks of a half generic thing, and then "I", who am the object of violence, who am suffering from violence, don't expose myself" (Provider, sex: M.).*

According to the providers interviewed, to come to terms with violence means finding ways of getting the story from the patient, of making him or her face the vivid scene and, at the same time, look for ways to respond to the situation. Among female adolescents, situations of violence are generally identified in the nursing care, in spite of these encounters being brief. It is more difficult to detect of situations of violence, as well as obtaining reports about living with violence, among boys. Since being a non-accomplice to violence is the obligation of every health professional, by not uncovering it, providers run the risk of not denouncing it. An example cited was the case of a minor who had suffered violence at the hands of the local police and who just asked to have his wounds and pains treated. He asks the providers "for God's sake, don't inform on him or I'll turn up dead tomorrow and I don't want to die".

> *"I don't think informing is a mistake, but there are specific situations in which if you inform you are exposing the patient … if we had a structure in which we could put the boy and leave him in a safe place, then we could make the accusation…" (Provider , Sex: Butantã).*

At present the Service has difficulty retaining clients who present with a situation of violence before it is identified and the client is sent to the mental health Service. In the opinion of the providers at the CSE-Butantã adolescent Program, dealing with the question of violence through mental health ends up conceptualizing it as a problem of mental health, which is usually not the case.

The Butantã providers affirm that for adolescents the problem of violence is very relevant and of growing visibility within the service. This has occurred, not merely because today there is more sensitivity toward the issue, but also because it constitutes a matter of growing social interest. In Butantã they make specific referrals to institutions that deal with various aspects of violence, in particular to those who deal with the cases of sexual abuse and domestic violence.[76]

At CSE Butantã, violence has been found to be intimately related to the question of drug use, especially to the use of crack. The association between drugs use and violence has also been found at PAM Maria Zélia, where, according to the providers, in the few cases of violence and rape they have seen, drug use has been involved. In one case of violent physical abuse from a mother to a minor child, the providers tried to help her.

[76] [5]They are cited as CEARAS - Sexual Abuse Study Center at the Faculty of Medicine of the University of São Paulo, which deals with legally proven cases of sexual abuse or of domestic violence; as PAVAS - Support Program for Victims of Sexual Abuse, also from the Faculty of Medicine at the USP; and the Elianne de Grammont House (team from the City Hall at the municipality of São Paulo).

4.6 - Drugs, alcoholism and other additions

At the PAM Maria Zélia, drug use is a subject that is treated only in the context of prevention. The actual problem of the users are not the object of attention at the PAM.

> *"Thank God that here too it is small [the demand for assistance as a function of the use of alcohol and drugs]. I think that by the constitution of the family itself, we don't have any big slum. Unfortunately, the Post is situated in a region where it is far away from everything…" (Provider 3, Sex: M, Maria Zélia).*

As with pregnancy and violence, the use of drugs is seen by this group of providers as a consequence of inadequate family structures. It is common to hear stories from the children about violent attitudes among their fathers. There are also stories about the use of alcohol among the parents of adolescents treated, although there are no statistics in the service. The Maria Zélia providers collect and record the stories told by the adolescents, but have not put together a collective proposal for care, either for adolescents who suffers violence, or from drug use. They feel impotent when faced with these problems, and by the lack of references for referrals.

At the Butantã, the group of providers agrees on the consensus that alcohol and drug abuse are a problem of health. However, they also recognize their difficulties in dealing directly with the problem, which is obvious in stories about families of drug/alcohol users, or even of those who are involved in the drug traffic network existing in the region. One providers indicated that there is even physical fear of involvement by the Service in drug theme issues, including the fear of provoking reactions in the community, and the fear of placing at risk the users who are linked to the service and who, as a result of that link, have made changes in their lives. It is not clear to the Service, however, what appropriate sector/area/professional would be the most appropriate to develop programs to address drug uses, and what those programs would be. The tradition of thinking about the drug problem as circumscribed to the field of mental health is seen as absolutely insufficient by the professionals who participate in the adolescent Program.

Chapter 5. Attention to Health from the Perspective of Users

The connection of adolescent users with the services depends on various issues, including how the service is perceived by the local community. Analysis of the interviews

conducted with users from the two selected areas, shows that many of the adolescents interviewed stated that they had used the health center since they were children (pediatric) or because their mother — generally also a user of the service — brought them to be seen in the Adolescent Program. Another group has used the service for no more than five years, with important differences in the reasons which determined their knowledge of and use of the service.

The Butantã School Health Center (CSE -Butantã) is seen by the population as a high quality Service, with some questions, however about the registration process. Both clients and providers interviewed noted difficulty in respecting the requirement that clients must come from only those who live in the Center's service area. Clients find ways of circumventing the rule, identifying themselves as residents of the region just to get service at CSE-Butantã. Despite their knowledge of the existence of other health stations in the region, they justified their preference for CSE-Butantã due to the quality of care. Comparison to the other existing alternatives serves only to reinforce the preference for CSE-Butantã.

At the PAM Maria Zélia, clients have a lack of knowledge of other services in the region; instead they tend to select the "hospital", as PAM is also known to its clients based on references given by friends and family.

The most convenient time for use of the Services is related to the schedule of school activities in the region. Thus, the morning hours in the case of the PAM Maria Zélia, and the afternoon in the case of CSE-Butantã were the preferred times. At both Services, providers who were interviewed described difficulties with the scheduling of appointments. At Maria Zélia, for example, the preferred hours are concentrated at the end of the morning, when clients hope to be seen quickly to have time to get to or back to school. The health professionals are not always available at these times, since, especially in the case of the PAM Maria Zélia, their time is already booked for other professional commitments. From the client's point of view, the difficulties were expressed in terms of waiting times for treatment. The adolescents from the Butantã School Health Center were relatively more critical than those who used the PAM Maria Zélia, despite the fact that they tended to spend less time in travel, not more than 15 minutes, generally by bus.

In the two facilities analyzed, the adolescents sometimes came alone, sometimes accompanied by others. At the Butantã School Health Center there has been a deliberate move to expanding the Services' entrance, making it more unorthodox from the point of

view of registering the adolescent. This new “entry way” according to the providers who were interviewed, has resulted in a variety of persons accompanying the adolescents to the Service: sister/brother, grandparent, daughter, spouse, school staff, and friends, among others. At the PAM Maria Zélia, the most frequent companion was the mother of the client.

At both health facilities, the demand for walk-in services for adolescents was not generally related reproductive health. This confirms the observation made by various providers interviewed in both Services that complaints defined as a generic feeling bad still constitute the principal reason for seeking care on the part of the adolescents. This characteristic is more accentuated among the males, since their spontaneous demand for reproductive health – related services is practically non existent. Among female adolescents, however the reasons for care can be divided among pre-natal, gynecological care, contraception, in addition to the more general complaints such as dizziness, feeling bad, and muscle pain, among others. CSE-Butantã providers pointed out as a positive the appearance of a small but growing spontaneous demand for contraception, as well as for participation in educational groups.

The information collected in the interviews with the clients is consistent with the type of assistance provided by the Services. The adolescents treated at the PAM Maria Zélia had a larger number of consultations than those clients from Butantã. In the latter, the adolescents are sent first to the general practitioner, as already mentioned, having access to the gynecologist only as a secondary referral. On the other hand, CSE-Butantã clients refer more frequently to having participated in discussion groups. The difference in the service delivery systems does not seem to affect the level of client satisfaction. In both Services, the adolescents interviewed largely expressed satisfaction with the attention received during the visit, saying that they had received the information and care they needed.

Clients mentioned that they felt timidity, shame, embarrassment, and fear, among other feelings in expectation of being seen by a doctor or health professional. They pointed out, however, that these feelings had been overcome because providers had an attitude that was “cool, open, which gave relief”, referring to the way in which they were able to interact with the professionals. They felt at home and had privacy during the consultations, although some clients mentioned, especially in the case of the PAM Maria Zélia, that they timid and unable to be open due to the presence of their mothers during the consultations.

Such issues merit attention. According to the interviews with CSE-Butantã providers, the presence of the mother during the consultation requires special care and is treated as an opportunity to explore with both the client and mother themes related to the autonomy of the adolescent. The objective is to show for the mother and child the potential for the adolescent to establish his or her own relationship with health, moving toward the development of autonomous and confidential relations among mother-provider-adolescent.

In general, the adolescents say that they had received explanations of the exams that would be performed, had their concerns listened to, had been able to ask the questions they wanted to ask, and considered that the providers always expressed themselves clearly. As one of the clients of the PAM Maria Zélia said:

> *"For me, the way it is perfect, even because the PAM Maria Zélia is a State hospital, public, and it is very difficult to have that kind of hospital offer the Program for adolescents. In the others, you are poorly treated by the doctor, who barely looks in your face. And here they give so much attention: it's the psychologist, the nurse, the dentist, the gynecologist. The people and the way they treat you is really cool and okay; if anything gets better, it gets better, but for me the way it is tops!" (Client 11, 18 years old, PAM Maria Zélia.).*

Clients' satisfaction with the services is also shown by the tendency of the adolescents to recommend them to friends and family, for a number of reasons: the service is free of charge; the range of professionals available; to have a larger number of participants in a group; because they were well treated; because of the service's physical facilities; or simply because they consider it important to take care of their health or have partners with whom to talk. The tendency not to recommend the Service to others is associated with factors external to the quality of the Service provided but because the adolescents: do not believe that their friends would be interested; do not wish to see their friends at the service; or because they assume that the Service is already reasonably well known by people who live in the region.

The few suggestions that arose for improvement of the Service are associated, overall, with reducing the lateness of providers, increasing ease in scheduling visits, improvements in the physical facilities, and increasing the educational work. In the two Services, providers noted that making schedules with adolescents carries with it an additional difficulty in the sense that young people's time dimension is different from that of adults. An adolescents motivation to stick with an activity can be lost in the middle term, making it difficult to adherence to the treatment plan.

The majority of those interviewed at the PAM Maria Zélia had access to and were interested in educational pamphlets, an aspect that, although mentioned, was not emphasized among the adolescents treated at CSE-Butantã. Although many of those interviewed could not recall the topics about which they read in the pamphlets, STDs/AIDS and cancer appeared among the topics mentioned in both Services. Among those

interviewed at Butantã, themes related to sexuality and reproductive health were predominantly mentioned, while at the PAM Maria Zélia more general topics were mentioned, such as, for example, dengue and diabetes. Among the greatest health concerns or worries to which interviewed clients referred were AIDS, other sexually-transmitted diseases, drugs, sexuality, pregnancy and unwanted pregnancy. Responses to this type of question were clearly longer and more detailed among clients at the PAM Maria Zélia, which can be explained by their higher educational level.[77] The speech of one of the young women interviewed, in the 8th grade at 16 years of age, expresses in a way the universe of questions and the form in which they are presented among these adolescents:

> *"Oh, I don't know, everyone has their own type of problem. Young people are very concerned with this sex thing. There are some people who say 'I'm going to do it' and they don't worry about anything. Lots of times they go with one, then with another, and they end up getting really sick. If you want to do it, you have to use your head to find some way of protecting against pregnancy, something. For me, pregnancy would be okay, but for my mom it would be the end of the world, I guess she wouldn't throw me out of the house, but she'd make me get married right away. I wouldn't do an abortion, in relation to STDs, AIDS, I'd look for a doctor and do everything I could. Even without AIDS, there are people who feel desperate, really think they're going to die and start using drugs, that kind of thing" (Client 14, 17 years old, Maria Zélia).*

For the adolescents from PAM Maria Zélia, as for those from the Butantã CSE the service is seen as an opportunity to establish a dialogue with the providers, an interaction they find more difficult to establish with their parents, whether due to fear or shame to speak about sex, pregnancy, AIDS or contraception. At Butantã, the topics which would lead to referring the service to friends would be orientations to topics such as an unwanted pregnancy and the provision of contraceptive methods. At Maria Zélia there is interest in conversing about sexuality and orientation to the topic of unwanted pregnancy. In both services, the young people seem to feel comfortable and confident with the treatment they receive.

To the question of what would be the most important health concerns and fears for people of their age, in both services the predominant response was AIDS, followed by pregnancy. In relation to AIDS, at the CSE-Butantã respondents said they didn't know what to do or stated that they would seek treatment at the center itself. At the PAM Maria Zélia, on the other hand, clients showed such fear relative to the subject of AIDS that they seemed to prefer to avoid even speaking of the possibility of prevention and infection by

[77] The characteristics of the clients interviewed in each service can be found in Addendum 2.

HIV or other STDs, as if they could thus protect themselves from any “danger” by remaining silent. In relation to pregnancy, most of the adolescents from both services would explain the situation to their parents and partners and would go ahead with motherhood - which definitely was not seen as a problem - since most of them stated that they were opposed to having an abortion. As for STDs, most would come to Butantã for treatment, expressing confidence in the service. The adolescents interviewed at Maria Zélia did not perceive violence, drugs and alcohol as health problems, believing that these were results of problems in their families, and they would seek solutions to these problems in religion. The adolescents from Butantã also did not believe violence, drugs and alcohol to be health problems. However, they did identify the service as a place where they could get direction on how to proceed if they faced these problems.

Chapter 6. Final Considerations

6.1 Democratization and Politics of Adjustment in Latin America

Brazil, like other Latin American countries is undergoing the effects of a process of re-democratization, slowly implemented after the breakdown of the controlling presence of the region’s authoritarian governments. Side-by-side with the political transformations, the processes of economic development are making the Latin American reality ever more complex and are creating important processes of social exclusion. Globalization, through its markets without frontiers, is moving jointly with the Reform of the State which has reserved an important place for the health sector. Such processes are important as they reflect on the other side the advance of democracy on one side and on the structural impact. It is in this context sense that the political and social commitments assumed by nations in international situations cannot always be maintained nationally. In the case of Brazil, for example, this difficulty has been evident since the end of the 1980s, through the process which established the Brazilian Constitution, a flourishing which brought to the fore and crystallized social questions and actors still present today on the national stage. The internationally recognized themes “right to health constituted as a universal right” and “adolescence” are examples.

At the federal level, at the same time that the conditions of financial sustainability and budgeting for the SUS are constantly in debate, there is also in evidence technical,

financial and political reconstruction in the area of adolescent and child health and women's health. These are the areas which, in the federal realm and associated to the area of prevention of STDs/AIDS, correspond to actions in the field of sexuality, reproductive health, sexual and reproductive rights. At the same time, adolescent health has benefited in the past few years from actions developed in Brazil by the women's movement, dealing with of sexuality and reproduction from the point of view of gender, and the construction of new rights, including sexual and reproductive rights, presupposing the existence of a State of Social well-being. In particular, since the Cairo and Beijing conferences, specific social actors who have appeared in support of women's health have also begun to do so in the name of adolescent health,[78] just as more conservative sectors have also broadened their scope of activity, bringing forward their concern with the "precocious" sexuality and pregnancy of young people, suggesting sexual abstinence as a solution. Some sectors in the Ministry of Health and the Catholic Church have worked closely together in this recent process. Thus, cuts in financial resources at both the federal and state levels have ended up affecting the functioning of health centers at the local level, truly compromising their ability to function. This is in strong contrast to the growing vitality and political energy of work developed by social movements and organizations that operate in the field of reproductive health.

6.2 Impact of destructuring the system in the daily practice with adolescents

In the two services studied, the deterioration of the health system is clear from the nostalgic tone with which the innovative experiments of the 1980s were described at PAM Maria Zélia, and in the perplexity of those who, despite having worked together for many years, have never before encountered such severe shortages, for example, in the availability of supplies or of medical exams to clients at the CSE -Butantã. The clear lack of supplies and of health professionals are the main complaints of the professionals interviewed. Although the adolescent clientele in this study did not identify problems with quality of care, the professionals interviewed fluctuated between showing a certain heroism in their daily activities — since, as they see, the assistance happens because of their own merits and efforts – and a critical reflection on the role of the State, its weakening as a provider of services and the impact of this situation on the health of the population, including adolescents.

[78] National Feminist Network for Health and Reproductive Rights; FEBRASGO—Brazilian Federation for Gynecology and Obstetrics; CFM — Federal Council of Medicine.

In the two services, it is evident in what was said by the interviewees that things could be better. A certain air of desolation is present in both services, although particularly in Butantã. In that service, scientific production and academic activity offer the opportunity to produce innovative models of care, however what students who assist in the activities end up learning predominantly focuses on the eventual external difficulties in the process of service delivery.

6.3 Different conceptions of integral approach

The integral holistic approach is a principle from SUS which, since the 1980s has been in debate, as Schraiber (1999) shows, being perceived as integration among separate institutions which offer service, or as management of services. As the author suggests, “it has always been made explicit as the intention and necessity for public action, that is, the interventions which consolidate the single Brazilian healthcare system, the SUS” (1999: 17). These distinct forms of thought and action concerning the integral approach were evident in this study. At Maria Zélia the perspective on integral approach is separate disciplinary approaches, characterized, as previously pointed out, by the existence of specialized knowledge in the service offered to patients in a fragmented manner which incidentally, increases probably the system’s costs. In the case of Butantã, it is possible to note the presence of team work and of a real effort to act a real effort to act coherently and jointly, to offer patients a single integrated understanding of their needs and ways of satisfying them. There is a tone of seeking transparency in institutional relations, whether among professionals in the same program or among professionals in this and other programs. At Butantã there is an effort to promote the citizenship and autonomy of the patients, even though this vision may not be shared by a few of the health professionals interviewed. Maria Zélia shows a didactic and informative approach, especially aimed at families and particularly mothers. Families and, in particular, mothers, would have, in the words and actions of the Service, the chance to get information, be oriented in their needs especially regarding motherhood but also adolescence.

In our view, regardless of the distinct conceptions of the integral approach which the services follow, they are having a hard time dealing with the presence of adolescents in the educative groups in which questions of sexuality and reproductive health, sexual and reproductive rights are most appropriately treated. In part, such difficulties can be attributed to the deterioration of the health system when, to reach this clientele would require larger teams and exclusive dedication to the program. In the case of Butantã, since the groups educational structure the program, there is concern over the because adolescents are not so involved, a fact which was not confirmed during the interviews.

Despite what appears to be a negative cost-benefit analysis, there is an awareness of the benefit, of the education groups can offer to the general population.[79]

6.4 Gender Perspective: impact on the attention to health

The gender perspective of the two services can be analyzed from the material collected in the field observations, the programmatic structures, the organization of the services and the interviews with health professionals, staff, and clients. From the point of view of the programmatic structure, , at this time of reorganization in the technical area of child and adolescent health at the federal level, there is no clear objective to develop policies which promote gender equity or equality.

In the interviews, as in the program texts, the only aspect of the program that tends to address gender issues is "the problem" of adolescent pregnancy. In the services, the complaints of males and females ages 10-15 are similar and begin with physical development, and imprecise complaints. As they grow older, sexuality becomes more important for both, although avoiding conception is, not surprisingly, more important to the females.

At the PAM Maria Zélia, the providers are sensitive to the existing differences between the daily domestic activities, of girls and boys. Girls engage in child-care activities for brothers, sisters or nephews, while boys tend to have no assigned domestic duties. The girls, at the PAM Maria Zélia, indicate a preoccupation with the weight and look of their bodies, a concern which does not exist for the boys. This concern with one's own body, the shame over exposing it during gynecological exams, seem to be better handled by the female professionals, particularly the professional nurses. Although the staff carry out similar activities with the boys, they don't feel that they could have the same easy connection that they can have with the girls. They consider that male professionals could connect more successfully with boys. Boys' ability to be subjective is considered much more complex than that of the girls. More timid, boys seem to have more difficulty in joining groups, and in individual treatment they also are more reticent. The clinician says that when investigating sexual life, the responses are generally evasive, always indicating that everything is "fine". In general the concerns tend to be more physical: size of penis, difficulty urinating or maintaining an erection. In any case, the service's organization permits clients to discuss more internal sexual problems with a psychologist.

[79] Success in inserting specific payment for educational groups was one of the successes related by one of the staff interviewed. However, it isn't possible to know how many of the programs

At Butantã the service is designed for girls much more than boys, even among the younger children, a fact which has surprised the providers. The service has equipped itself to respond to the eventual needs of boys, who will probably demand attention to questions as yet unknown or little explored, such as those associated with drugs and/or violence. Since all that is discussed about reproduction is that it is the female's responsibility, it is difficult to promote changes in the males' attitudes, and even changes in the culture in a more general way. Perhaps one of the most important questions raised in the interviews with providers was the perception that health services are identified with what is feminine. The challenge remains: how to promote this change? The majority of health professionals are females, the majority of patients are females, demands in the field of reproduction are culturally associated only with the female, all of which make expanding to meet the needs of males.

On the subject of adolescent pregnancy, with the bio-medical literature tends to see it as a health problem, the same does not hold true for the adolescents themselves. Some epidemiological data suggests that early pregnancy carries consequences both for the mother and the child, however there is not a consensus on this point. In the view of the adolescents however, pregnancy and the perspective of having a child are, in many cases, possibilities that are positively seen in their life plans. Contrary to the expected life styles of middle or upper class girls, pregnancy among girls of the lower classes integrates the means of sociability in their social medium, establishing a way to affirm their self-esteem.

This assertion seem to emerge from real experience in the health services dealing with adolescents that wish to get pregnant, as stated by one of the providers interviewed:

> *"It gets established as a standard (of early pregnancy) and must be studied as such. There are a number of people living on outside of city limits, in the slums of the big cities, which for the women, (to have a child) is a means establishing their identity" (*Employee 4, Sex: M, Butantã).

6.5 The Rights Perspective: impact on attention to health

This research allows us to affirm that there is in the healthcare environment, especially at the local levels, an important acceptance of adolescence as a socially constructed stage in life, which today clearly is constituted as having rights in the fields of sexuality and reproductive health, to which the public health services must respond, forming a more emphatic alliance with the adolescents than with their families. Nevertheless, the following questions remain:

a. At what level these services should/can/have elements to respond to demands?

b. What adolescent population do they succeed in reaching with their actions?

c. With what content can they operate, considering their inclusion in a scenario of rapid transformation of the role of the State in global economies?

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incorporated this strategy.

To offer information and build citizenship with equity is a growing perspective, but one which more or less strongly equates itself with dependence on the perspective and mission of each individual service. To what point is offering information — so defended during the 1980's — sufficient today to promote citizenship? Will it be enough for the services to respond more concretely to the demands promoting in fact an interaction, and dialog among the individuals and the institutions?

It was possible to observe, for example, that despite having in general less academic background, the adolescents interviewed at Butantã pointed out in a more complex manner the issues they faced regarding sexuality and reproductive health. They seemed to have a clearer perspective on their needs and rights, in contrast to the clientele at Maria Zélia, who brought a perspective less conscious of the possibility of facing these issues in their daily lives.

6.6 Challenges and General Recommendations

This research indicates how important it is to maintain spaces in the health care units which can meet the needs of adolescents in the field of sexuality, reproductive health and sexual and reproductive rights. Although such programs are suffering from the constraints that the reform of the State has imposed on the health sector, in Brazil there is an important potential for growth of the adolescent programs. Adolescent programs can benefit from the experience built into the SUS as a result of the implementation of women's health services. The process of reflection and implementation of the PAISM opened space in society for the formulation of health-related actions to promote of awareness and expansion of sexual and reproductive rights. Health programs aimed at adolescents can build on this experience in the sense that they can broaden societal perspectives on understanding male adolescents in addition to female adolescents, at the same time, adolescent programs could use the news social perspective to address questions still excluded or precariously connected, such previously neglected issues, such as violence and use of alcohol and drugs. At the same time, it would be possible to more fully understand men's relationships with contraception and with reproduction itself.

This research points to the need for more reflection on the ways which the health system could provide different services depending from the structure of the health system for basic attention or for ambulatory care for specialties. The potential for joint action wise local communities depends on the service's characteristics, and on the technical supervision offered by the service. The work of the service with groups directly constituted in the community appears to be most efficacious. The greatest difficulty in this regard is the institutional barriers which define health teams only as sources for resolution of medical complaints. Adolescent services, as represented by the two studied here, need to reformulate how they relate to adolescents and seek more differentiated forms of care to overcome obstacles noted by the adolescents. For example, adolescents do not like to

have to wait long hours for care; some will not wait for this attention. Furthermore, the health services should find ways to offer more adequate services for adolescents, keeping in mind the range of the needs during this life cycle stages.

Finally, the revision of the Penal Code will be set itself as a relevant instrument to enlarge the debate around the rights and responsibilities of adolescents in the field of sexuality, maternity and paternity. At the same time, more innovative positions, like those being produced by important social actors should be made more and more visible, such as those from FEBRASGO (Brazilian Federation for Gynecology and Obstetrics) and the Federal Council for Medicine, which are supporting the Cairo Platform. Sexuality among adolescents aged 10-14, sexual abuse and adolescent pregnancy merit much more research efforts, debate and intervention in governmental and non-governmental programs.

ADDENDUNN I:TABLES AND CHARTS

Table 1
Annual Mortality Rate(*10,000) of Adolescents
Municipality and State of São Paulo
1980-1994

State of São Paulo

	10-14		15-19	
	80	***94***	***80***	***94***
Male	6.81	5.86	15.80	21.95
Female	4.16	3.50	6.94	6.29
Total	5.50	4.70	11.33	14.17

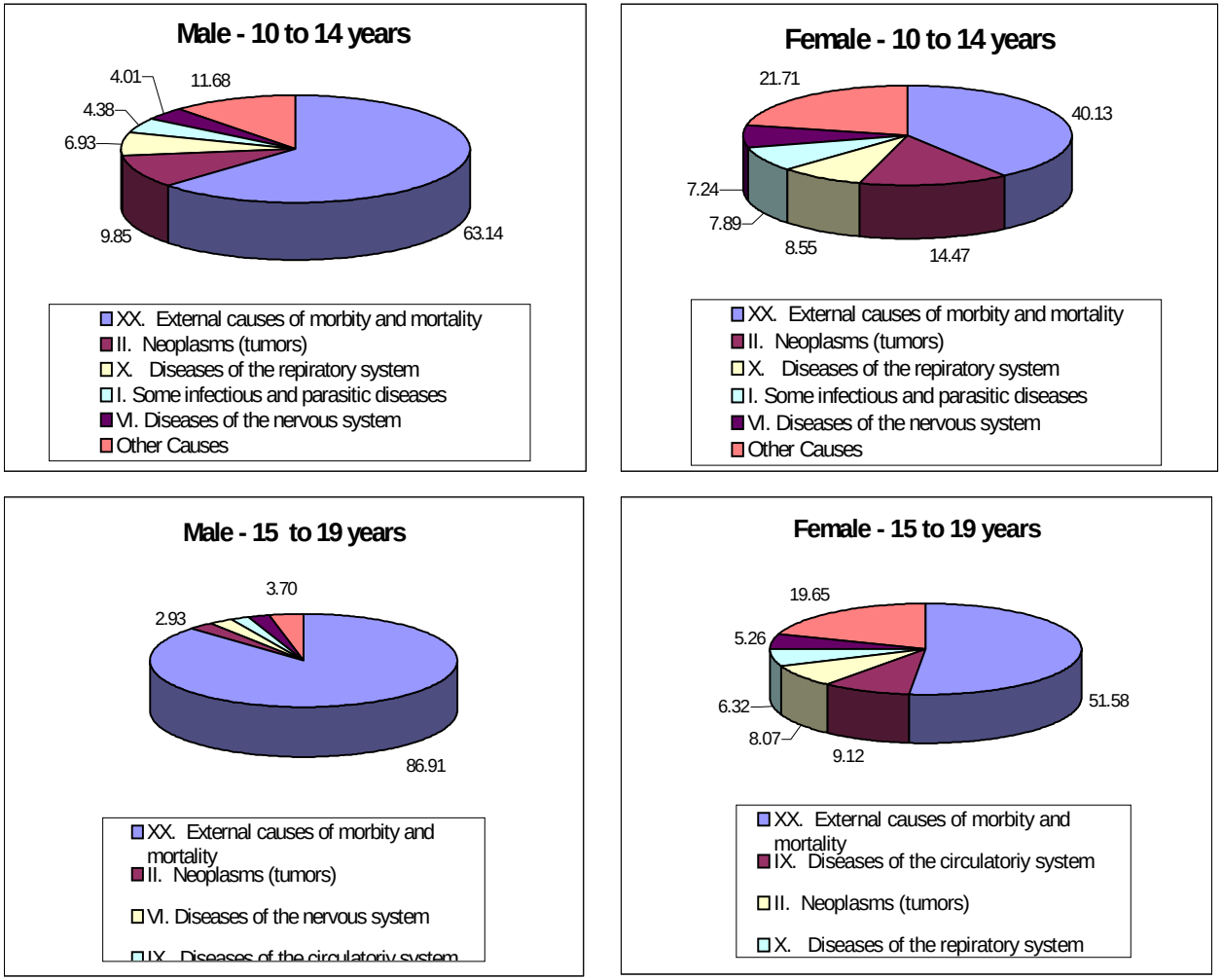
Municipality of São Paulo

	10-14		15-19	
	80	***94***	***80***	***94***
Male	6.74	6.03	18.64	29.71
Female	4.11	3.50	6.64	6.89
Total	5.42	4.77	12.43	18.16

Source: SIM. DATASUS/M.S./FNS.
FIBGE- Demographics Census,1980. Populations Projection,1994
Special tabulations NEPO/UNICAMP

Figure I

Proportional Mortality by Larger Category of Causes of Death
Municipality of São Paulo
1997



Source: Fundação Sistema Estadual de Análise de Dados - SEADE.
Special tabulations NEPO/UNICAMP

Table 2
Proportional Mortality by infectious and parasitic diseases
Municipality and State of São Paulo
1997

Municipality of São Paulo

	10-14 years						15-19 years						Total					
Causes	**Male**		**female**		**Total**		**male**		**female**		**Total**		**male**		**female**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
AIDS	1	8.33	3	25.00	4	16.67	5	27.78	5	33.33	10	30.30	6	20.00	8	29.63	14	24.56
Tuberculosis	4	33.33	2	16.67	6	25.00	4	22.22	3	20.00	7	21.21	8	26.67	5	18.52	13	22.81
Septicemia	2	16.67	1	8.33	3	12.50	1	5.56	1	6.67	2	6.06	3	10.00	2	7.41	5	8.77
Other causes	5	41.67	6	50.00	11	45.83	8	44.44	6	40.00	14	42.42	13	43.33	12	44.44	25	43.86
Total	12	100.00	12	100.00	24	100.00	18	100.00	15	100.00	33	100.00	30	100.00	27	100.00	57	100.00

State of São Paulo

Causes	**Male**		**female**		**Total**		**male**		**female**		**Total**		**male**		**female**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
AIDS	3	7.69	7	21.21	10	13.89	24	32.88	22	40.74	46	36.22	27	24.11	29	33.33	56	28.14
Tuberculosis	6	15.38	2	6.06	8	11.11	14	19.18	10	18.52	24	18.90	20	17.86	12	13.79	32	16.08
Septicemia	14	35.90	8	24.24	22	30.56	17	23.29	8	14.81	25	19.69	31	27.68	16	18.39	47	23.62
Other causes	16	41.03	16	48.48	32	44.44	18	24.66	14	25.93	32	25.20	34	30.36	30	34.48	64	32.16
Total	39	100.00	33	100.00	72	100.00	73	100.00	54	100.00	127	100.00	112	100.00	87	100.00	199	100.00

Source: SIM. DATASUS/M.S./FNS.
Special tabulations NEPO/UNICAMP

Table 3

Proportional Morbitity by the Larger Causes of Hospitalzation
State of São Paulo and Municipality of de São Paulo
1998

ICD Chapter	São Paulo																	
	10-14 years						15-19 years						Total					
	Male		Female		Total		Male		Female		Total		Male		Female		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
I. Some infectious and parasitic diseases	1756	4.74	1227	4.30	2983	4.55	1357	3.34	1353	0.84	2710	1.35	3113	4.01	2580	1.36	5693	2.13
II. Neoplasms (tumors)	1360	3.64	948	3.32	2298	3.50	1405	3.46	1356	0.84	2761	1.37	2755	3.55	2304	1.22	5059	1.90
III. Blood diseases of the hematological system and tr	453	1.22	383	1.34	836	1.27	365	0.90	482	0.30	847	0.42	818	1.05	865	0.46	1683	0.63
IV. Endrocronogical and Metabolic nutritional disease	782	2.11	893	3.13	1675	2.55	562	1.38	743	0.46	1305	0.65	1344	1.73	1636	0.86	2980	1.12
V.Mental and behavioral disturbances	650	1.75	460	1.61	1110	1.69	3859	9.50	1841	1.15	5700	2.83	4509	5.80	2301	1.22	6810	2.55
VI. Diseases of the nervous system	1150	3.10	881	3.09	2031	3.10	1047	2.58	963	0.60	2010	1.00	2197	2.83	1844	0.97	4041	1.51
VII. Disease of the eye and related disorders	439	1.18	356	1.25	795	1.21	502	1.24	465	0.29	967	0.48	941	1.21	821	0.43	1762	0.66
VIII.Diseases of the ear and mastoid related disorders	510	1.38	425	1.49	935	1.43	272	0.67	252	0.16	524	0.26	782	1.01	677	0.36	1459	0.55
IX. Diseases of the circulatory system	669	1.80	546	1.91	1215	1.85	978	2.41	981	0.61	1959	0.97	1647	2.12	1527	0.81	3174	1.19
X. Diseases of the repiratory system	4646	12.53	4135	14.50	8781	13.39	3962	9.75	4271	2.66	8233	4.09	8608	11.08	8406	4.44	17014	6.38
XI. Diseases of the digestive tract	3980	10.74	2316	8.12	6296	9.60	4253	10.47	3599	2.24	7852	3.90	8233	10.59	5915	3.13	14148	5.30
XII Diseases of the skin and subcutaneous tissue.	903	2.44	632	2.22	1535	2.34	1109	2.73	1027	0.64	2136	1.06	2012	2.59	1659	0.88	3671	1.38
XIII.Osteomuscular and conjunctive tissue diseases	1620	4.37	1089	3.82	2709	4.13	1846	4.54	1210	0.75	3056	1.52	3466	4.46	2299	1.22	5765	2.16
XIV. Diseases of the genitourinary system	2956	7.97	1551	5.44	4507	6.87	2218	5.46	6968	4.34	9186	4.56	5174	6.66	8519	4.50	13693	5.13
XV. Pregnancy, childbirth and puerperium	0	0.00	5391	18.90	5391	8.22	0	0.00	125204	77.94	125204	62.20	0	0.00	130595	69.03	130595	48.93
XVI. Some conditions of perinatal origin	86	0.23	91	0.32	177	0.27	12	0.03	208	0.13	220	0.11	98	0.13	299	0.16	397	0.15
XVII.Congenital malformations and chromosome anom	3781	10.20	2953	10.35	6734	10.27	3468	8.53	3177	1.98	6645	3.30	7249	9.33	6130	3.24	13379	5.01
XVIII.Symptams, signs and abnormalities found in clin	924	2.49	664	2.33	1588	2.42	764	1.88	950	0.59	1714	0.85	1688	2.17	1614	0.85	3302	1.24
XIX.Lesions, poisoning and other external causes	8567	23.11	2694	9.45	11261	17.17	10298	25.34	2951	1.84	13249	6.58	18865	24.28	5645	2.98	24510	9.18
XX. External causes of morbity and mortality	703	1.90	235	0.82	938	1.43	995	2.45	369	0.23	1364	0.68	1698	2.19	604	0.32	2302	0.86
XXI. Contact with health services	787	2.12	396	1.39	1183	1.80	950	2.34	797	0.50	1747	0.87	1737	2.24	1193	0.63	2930	1.10
ICD 10th Edition not available or not completed	359	0.97	257	0.90	616	0.94	416	1.02	1484	0.92	1899	0.94	774	1.00	1741	0.92	2515	0.94
Total	**37071**	**100.00**	**28523**	**100.00**	**65594**	**100.00**	**40637**	**100.00**	**160651**	**100.00**	**201288**	**100.00**	**77708**	**100.00**	**189174**	**100.00**	**266882**	**100.00**

ICD Chapter	Municipality of São Paulo																	
	10-14 years						15-19 years						Total					
	Male		Female		Total		Male		Female		Total		Male		Female		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
I. Some infectious and parasitic diseases	282	3.27	206	3.42	488	3.33	204	2.19	150	0.49	354	0.88	486	2.71	356	0.97	842	1.54
II. Neoplasms (tumors)	604	7.01	381	6.32	985	6.73	619	6.64	578	1.88	1197	2.99	1223	6.82	959	2.61	2182	3.99
III. Blood diseases of the hematological system and tr	200	2.32	192	3.18	392	2.68	137	1.47	154	0.50	291	0.73	337	1.88	346	0.94	683	1.25
IV. Endrocronogical and Metabolic nutritional disease	142	1.65	176	2.92	318	2.17	122	1.31	151	0.49	273	0.68	264	1.47	327	0.89	591	1.08
V Mental and behavioral disturbances	73	0.85	53	0.88	126	0.86	626	6.72	388	1.26	1014	2.53	699	3.90	441	1.20	1140	2.08
VI Diseases of the nervous system	361	4.19	293	4.86	654	4.47	332	3.56	304	0.99	636	1.59	693	3.87	597	1.62	1290	2.36
VII. Disease of the eye and related disorders	257	2.98	218	3.61	475	3.24	277	2.97	290	0.94	567	1.41	534	2.98	508	1.38	1042	1.90
VIII.Diseases of the ear and mastoid related disorders	202	2.35	142	2.35	344	2.35	115	1.23	98	0.32	213	0.53	317	1.77	240	0.65	557	1.02
IX. Diseases of the circulatory system	228	2.65	215	3.56	443	3.02	347	3.72	287	0.93	634	1.58	575	3.21	502	1.36	1077	1.97
X. Diseases of the repiratory system	752	8.73	633	10.49	1385	9.46	555	5.96	540	1.76	1095	2.73	1307	7.29	1173	3.19	2480	4.53
XI. Diseases of the digestive tract	809	9.39	436	7.23	1245	8.50	859	9.22	620	2.02	1479	3.69	1668	9.30	1056	2.87	2724	4.98
XII Diseases of the skin and subcutaneous tissue.	224	2.60	164	2.72	388	2.65	317	3.40	335	1.09	652	1.63	541	3.02	499	1.36	1040	1.90
XIII.Osteomuscular and conjunctive tissue diseases	559	6.49	396	6.55	954	6.51	579	7.29	433	1.41	1112	2.77	1238	6.91	828	2.25	2066	3.78
XIV. Diseases of the genitourinary system	789	9.16	296	4.89	1084	7.40	516	5.53	910	2.96	1425	3.56	1304	7.27	1205	3.27	2509	4.58
XV. Pregnancy, childbirth and puerperium	0	0.00	915	15.17	915	6.25	0	0.00	23948	77.84	23948	59.75	0	0.00	24863	67.56	24863	45.43
XVI. Some conditions of perinatal origin	5	0.06	7	0.12	12	0.08	0	0.00	57	0.19	57	0.14	5	0.03	64	0.17	69	0.13
XVII.Congenital malformations and chromosome anom	556	6.46	360	5.97	916	6.25	360	3.76	392	1.27	742	1.85	906	5.05	752	2.04	1658	3.03
XVIII.Symptams, signs and abnormalities found in clin	359	4.17	232	3.85	591	4.04	145	1.56	136	0.44	281	0.70	504	2.81	368	1.00	872	1.59
XIX.Lesions, poisoning and other external causes	1790	20.78	531	8.80	2321	15.85	2629	28.22	712	2.31	3341	8.34	4419	24.65	1243	3.38	5662	10.35
XX. External causes of morbity and mortality	136	1.58	32	0.53	168	1.15	161	1.73	70	0.23	231	0.58	297	1.66	102	0.28	399	0.73
XXI. Contact with health services	285	3.31	156	2.59	441	3.01	327	3.51	214	0.70	541	1.35	612	3.41	370	1.01	982	1.79
Total	**8613**	**100.00**	**6032**	**100.00**	**14645**	**100.00**	**9316**	**100.00**	**30767**	**100.00**	**40083**	**100.00**	**17929**	**100.00**	**36799**	**100.00**	**54728**	**100.00**

Source: Datasus/MS/FNS 1998.
Special tabulations: NEPO/UNICAMP

Table 4
Prevalence rate of AIDS
São Paulo
1996
Cases (per 100.000 inhab) by age groups

Age category	
10-14	1.70
15-19	13.00

Source: MS/DST/AIDS
Special tabulations: NEPO/UNICAMP.

Table 5
Incidence rate of AIDS
São Paulo
1996
New cases (per 100.000 inhab) by age groups according to residence

Age category	
10-14	0.4
15-19	3

Source: MS/DST/AIDS
Special tabulations: NEPO/UNICAMP.

Table 6
Adolescent mortality rate for AIDS (per 100000)
Municipality of São Paulo
1996

	10-14 years			**15-19 years**			**Total**		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Municipality São Paulo	1.08	0.43	0.76	2.61	1.66	2.12	1.84	1.06	1.45
State of São Paulo	0.52	0.24	0.38	2.85	1.59	2.22	1.67	0.91	2.6

Source: SEADE, Vital Statistics
Special tabulations: NEPO/UNICAMP

Table 7
Number and percent of Hospitalizations for AIDS
Municipality os São Paulo and State of São Paulo
1998

	10-14 years						15-19 years						Total					
ICD 3 digits	**Male**		**Female**		**Total**		**Male**		**Female**		**Total**		**Male**		**Female**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Municipality of São Paulo	48	68.57	22	104.76	70	100.00	21	77.78	6	22.22	27	100.00	69	71.13	28	28.87	97	100.00
State of São Paulo	64	68.09	30	40.00	94	100.00	75	58.59	53	41.41	128	100.00	139	62.61	83	37.39	222	100.00

Source: MS/DST/AIDS
Special tabulations: NEPO/UNICAMP

Table 8
Number and percentage of women who use birth control
São Paulo
1996

	Women		Men	
Use	**N**	**%**	**N**	**%**
Never used	400	82.79	33	33.67
Only traditional methods	10	2.05	4	4.08
Modern methods	73	15.16	61	62.24
Total	**483**	**100.00**	**98**	**100.00**

Source: PNDS, BENFAM,1996.
Special tabulations: NEPO/UNICAMP.

Table 9

Proportional Mortality by complications of pregnancy, childbirth and puerperium
Muncipality of São Paulo and State of São Paulo
1997

Causes	Municípality of São Paulo		State of São Paulo	
	N	%	N	%
Abortion	1	6.67	3	6.25
Gestastional hypertension	1	6.67	3	6.25
Eclampsia	2	13.33	4	8.33
Medical intervention for fetus distress	2	13.33	5	10.42
Embolism of obstetric origin	0	0,00	2	4.17
Infectious and parasitic diseases	1	6.67	1	2.08
Other maternal diseases	7	46.67	14	29.17
Other causes	1	6.67	16	33.33
Total	**15**	**100.00**	**48**	**100.00**

Source: SEADE, Vital Statistics
Special tabulations: NEPO/UNICAMP

Table 10
Percentage of adolescents ages 15 -19 who are mothers or are expecting first child, by selected characteristics
São Paulo
1996

		Expecting	Total of any	Number of
	Mothers	first child	time pregnant	Adolescents
São Paulo	13.9	3.7	17.6	483

Source: PNDS, BENFAM,1996.
Special tabulations: NEPO/UNICAMP.

Table 11

Birth weight of Adolescent Mothers Children

Municipality of São Paulo and State of São Paulo:1997

	State of São Paulo					
Birth weight	**10-14 years**		**15-19 years**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**
< 1 Kg	63	1.43	768	0.58	831	0.60
1kg a 2,4kg	616	14.03	12603	9.45	13219	9.59
2,5 Kg or +	3713	84.54	120037	89.98	123750	89.80
Total	**4392**	**100.00**	**133408**	**100.00**	**137800**	**100.00**

Source: SEADE, Vital Statistics
Special tabulations: NEPO/UNICAMP

	Municipality of São Paulo					
Birth weight	**10-14 anos**		**15-19 years**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**
< 1 Kg	13	1.36	207	0.59	220	0.61
1kg a 2,4kg	149	15.54	3431	9.80	3580	9.95
2,5 Kg or +	797	83.11	31377	89.61	32174	89.44
Total	**959**	**100.00**	**35015**	**100.00**	**35974**	**100.00**

Source: SEADE, Vital Statistics
Special tabulations: NEPO/UNICAMP

Table 12

Rates of Nati-Mortality, Infant Mortality and Maternal Mortality by Age of Mother
Municípality of São Paulo and State of São Paulo
1997

	São Paulo			Municípality of São Paulo		
	Rates			**Rates**		
Age	**Mortality**		**Natimorta-**	**Mortality**		**Natimorta-**
Category	**Infantile**	**Maternal**	**Lity**	**Infantile**	**Maternal**	**lity**
	(1)	**(2)**	**(1)**	**(1)**	**(2)**	**(1)**
10-14	48.28	43.91	13.41	50.18	0.00	12.54
15-19	27.49	35.37	10.33	24.97	41.73	10.56
10-19	28.16	35.65	10.43	25.67	40.56	10.61

Source: SEADE, Vital Statistics
Special tabulations: NEPO/UNICAMP
(1) * 1.000
(2) * 100.000

ADDENDUNN 2: Selected Characteristics of interviewees

ADOLESCENTS
CSE BUTANTÃ

No.	AGE	SEX	REASON FOR CONSULTATION	MIGRANT	OCUPATION	EDUCATION
01	12	M	Psychological visit	No	Doesn't work	3rd grade
02	16	F	Diaphragm	No	Yes (didn't answer)	8th grade
03	18	F	Pre-natal	Yes	Doesn't work	3rd grade
04	17	F	Pre-natal	No	Doesn't work	1st year HS
05	14	M	Growth follow-up	No	Doesn't work	8th grade
06	18	F	Placement of IUD	No	Doesn't work	4th grade
07	17	F	Placement of IUD	Yes	Doesn't work	1st year HS
08	12	M	Test result s	No	Doesn't work	5th grade
09	13	M	Dizziness, not feeling well	No	Doesn't work	7th grade
10	18	F	No complaint	No	Doesn't work	2nd year HS
11	13	M	Test results	Yes	Doesn't work	6th grade
12	12	F	No complaint / group	No	Doesn't work	6th grade
13	17	F	Muscle ache	Yes	Maid	5th grade
14	15	F	No complaint / group	No	Doesn't work	8th grade
15	18	F	Placement of IUD	No	Doesn't work	5th grade

ADOLESCENTS

MARIA ZÉLIA PAM

No.	AGE	SEX	REASON FOR CONSULTATION	MIGRANT	OCUPATION	EDUCATION
01	15	F	Weakness	Yes	Doesn't work	1st year HS

02	13	F	No complaint / group	No	Doesn't work	6th grade
03	12	F	Abdominal pain	No	Doesn't work	6th grade
04	16	F	Abdominal pain	Yes	Babysitter	2nd year HS
05	15	F	Asthma	No	Doesn't work	1st year HS
06	17	M	Treatment of thorax fracture	No	Doesn't work	2nd year HS
07	16	F	Inflammation in the uterus	No	Doesn't work	7th grade
08	16	F	Irregular menstruation	No	Doesn't work	1st year HS
09	18	F	Pre-natal	Yes	Doesn't work	8th grade
10	16	M	Toothache	No	Doesn't work	1st year HS
11	18	F	Lump in the breast, anemia	Yes	Doesn't work	3rd year HS
12	13	F	Pre-natal	No	Doesn't work	6th grade
13	13	M	No complaint / group	No	Doesn't work	8th grade
14	17	F	Stomachache	No	Doesn't work	3rd year HS
15	16	F	Gynecological Routine Examination	No	Doesn't work	8th grade

PROVIDERS

MARIA ZÉLIA PAM

No.	POSITION	SEX	AGE	PROFESSION	TRAINING WITH ADOLESCENTS	AMOUNT OF TIME ON THE JOB
01	Program Coordinator	F	39	Nurse	Yes, courses on sensitivity and ability to care for adolescents	14 years
02	Medical Clinician	F	42	Doctor	Yes, practical courses for outpatient care	4 years
03	Medical	M	41	Doctor	Yes, courses on caring for	14 years

	Clinician				adolescents	
04	Individual and group psychological assistance	F	57	Psychologist	Note: several courses, but none specifically on how to care for adolescents	3 years
05	Medical Director	M	43	Doctor	Note: informative courses and not academic (SIC)	14 years

PROVIDERS

CSE BUTANTÃ

No.	POSITION	SEX	AGE	PROFESSION	TRAINING WITH ADOLESCENTS	AMOUNT OF TIME ON THE JOB
01	Psychological assistance and program management	F	28	Psychologist	Specialization in Group Health with internship in the Adolescent Health Program.	1 year and a half
02	Medical Clinician	M	37	Doctor	Yes – Reproductive Health	6 years
03	Medical Clinician and Pre-Natal	F	36	Doctor	No	13 years
04	Gynecological Clinician	M	41	Doctor	No	7 years

PUBLIC OFFICIALS

No.	POSITION	SEX	AGE	PROFESSION	AMOUNT OF TIME ON THE JOB
01	PROSAD Coordinator/Health Department	F		Doctor	6 months
02	PROSAD Coordinator – State Health Department	F	47	Doctor	16 years
03	Former Coordinator of PROSAD/Health Department	F	48	Doctor	4 years
04	Adolescent Health Program Coordinator of CSE Butantã	M	38	Doctor	16 years

V. COMPARATIVE ANALYSES OF CASE STUDIES

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1. A comparison of epidemiological data

As an introduction to this chapter where the three case studies are compared, we will highlight some of the main conclusions to which we arrived after looking at the epidemiological profiles developed for this study.

It is important to note that in Buenos Aires, the adolescent population constitutes 14% of the total population, 10% in Sao Paulo and nearly 20% in México D.F. The situation in these cities is, compared to the general situation in the rest of each country, privileged both in its socioeconomic and educational levels as in the health and schooling conditions of its population. Still, there are important deficiencies that affect adolescents as a whole. One example is the percentage of the population ages 15-19 who are not in school: 25% in Buenos Aires, 35% in Sao Paulo, and 40% in México D.F.[80]

Even when the epidemiological information available on this age group presents important deficits[81], the diagnosis made uncovers a definitely worrying picture. Even though their magnitudes vary, the hierarchy of problems which compromise adolescents' lives and their health are similar in the three cities. It is important to remark how much violence weights, in terms of mortality and morbidity, as well as its differential incidence according to sex/gender.

The mortality rate for males ages 15-19 in the three cities is higher than for women of the same age group (twice as much in Buenos Aires and México D.F. and four times higher in Sao Paulo). Buenos Aires has the lowest adolescent mortality rate and México D.F. the highest. It is also interesting to note that in Buenos Aires, the mortality rate for males 15-19 is lower than for women of the same age group in the other two cities.

In Buenos Aires and Sao Paulo "external causes" constitute the first cause of death for adolescents (10-14 and 15-19) from both sexes; the percentages are always higher among males than among females. In the case of México D.F., the way in which the available data is disaggregated does not allow for an accurate estimate of the leading cause of death for this population. According to the available data, neoplasms appear as the first cause, followed by accidents. The fact that in males ages 15-19, 49% of the cases are concentrated under "other causes" evidences the existence of problems in the quality of this information. We can assume that, as in the other two places, the leading cause of death is actually represented by external

[80] The data available on the poverty conditions of households with adolescents for the three cities are not comparable (The data available in Sao Paulo is about household income, in Buenos Aires the poverty indicators used are households NBI (unmet basic needs) and below the poverty line; and in México D.F. households in conditions of poverty and extreme poverty).

[81] For example, data not appropriately disaggregated by sex, age group, geographical area or cause of mortality and/or lack of data, discontinuous data, differences in classification criteria along time, etc.

causes (accidents as well as other forms of violence included under the category "other causes").

Regarding maternal mortality, 5% of the deaths of women ages 15-19 in Sao Paulo and 8% México D.F. are related to maternal causes[82]. These proportions are a warning about the urgent need to improve the quality of prenatal care and the capacity of response of the health care services. As expected for this age group, the weight of maternal causes is lower than that of external causes and neoplasms in both cities. In Sao Paulo, for example, external causes explain 50% of the deaths of females ages 15-19.

In terms of morbidity, we only have data for Buenos Aires and Sao Paulo. In both cities traumatisms and poisoning are the leading cause for hospital discharges of males ages 10-14 and 15-19 as well for females ages 10-14.

As expected, normal deliveries and complications related to pregnancy, delivery and postpartum are the main cause of hospital discharge for females 15-19 in both cities and also the leading cause of hospital discharge in females 10-14 in Sao Paulo. Only in the case of Buenos Aires we can distinguish within the category obstetric discharges, between those corresponding to normal deliveries and those corresponding to pregnancy, delivery and postpartum complications. In this city, excluding delivery, 80% of hospital discharges correspond to direct obstetric causes (toxemia, hemorrhage and sepsis) and 18% (a relatively high percentage) to abortions. This figures evidence that, despite the legal prohibition of this practice, adolescents frequently expose themselves to unsafe abortions with the serious consequences that this can mean to their health.

Another reproductive health problem affecting adolescents is HIV/AIDS. In the three countries the average age of AIDS cases indicates that those people were infected during their adolescence. Reported adolescent AIDS cases (ages 10-19) represent 2% of the total accumulated cases in Argentina and México, and 2.5% in Brazil.[83] In this age group, the proportion of males who suffer AIDS is practically three times higher than the proportion of women with such disease in México and Argentina. Differences by sex/gender can also be observed in the means of transmission. In Argentina as well as in the State of Sao Paulo, the main means of HIV transmission in adolescent males is the use of intravenous drugs, and in adolescent women heterosexual sex. In the case of México, the information about means of HIV transmission presents some limitations since they are not reported for a significant percentage of cases. Differing from the other two cases, in México HIV infection through blood in

[82] There are no adolescent maternal deaths reported in Buenos Aires.
[83] 20% of adolescent AIDS cases in Argentina correspond to the City of Buenos Aires.

adolescents from both sexes ages 10-14 has greater importance. In males ages 15-19 the main means of HIV transmission is homosexual sex, and in females of the same age group, heterosexual sex.

Data on the prevalence of other STDs among adolescents is scarce and not very reliable in any of the three countries. In the case of México, a survey conducted on a representative sample of male residents of México D.F. shows that approximately 5% of adolescents between 15 and 19 years of age had suffered from an STD during their lives, and 1.6% had presented this type of disease during the year previous to the survey (1992-1993).

Regarding substance abuse (alcohol, tobacco and illegal drugs), unfortunately the limitations on the available data do not allow for reliable comparisons.[84]

Concluding, the comparison of epidemiological diagnosis provides important input for the design of policies and programs which, from a holistic perspective, could meet the health needs of the adolescent population. The significant weight that violence has in adolescent morbidity and mortality claims greater attention to the need to promote healthy behavior and ensure effective action for adolescent development, tasks which certainly exceed the responsibility of the health sector and which require intersectoral coalitions and community involvement. As clearly stated in the Report of the Round Table on Adolescent Sexual and Reproductive Health, health promotion is needed to prevent unwanted pregnancies, STDs and HIV/AIDS but also substance abuse and unintentional and intentional injury and their consequences as well as cancer and cardiovascular and respiratory diseases (UNFPA-ICPD+5, 1998, P. 25).

Finally, comparing the available epidemiological information and/or the information which was processed ad hoc for this study, makes clear the urgent need to improve the quality of the data and guarantee its periodicity, given that “evidence is essential if resource allocation for adolescent health is to be given greater priority in the future” (ibid. UNFPA-ICPD + 5).

2. About selected programs and services

In this report’s Introduction, some of the main similarities and differences between the programs and services included in the study were pointed out. As above mentioned, all of them are aimed at providing health care, particularly reproductive health care, to adolescents. However, some differences must be remembered in order to proceed with comparative analysis. Among them, the health care level which they belong to (health center, outpatients clinic, hospital), target population (adolescents from both sexes in four of the six selected services and women only in the other two, which depend on Gynecology/Obstetrics services). We have also

pointed out differences regarding the program or service's focus: in some cases it is more comprehensive (adolescents' integral health) and in others more restricted (reproductive health and sexuality). Finally, we must remember that there are also differences in the mix of professions included in health teams (general physicians predominate in some of them and gynecologists and/or pediatricians in others).

In the following section we will introduce a systematic comparison of the similarities and differences found among the three cases (and in each of them when relevant), and we will derive from them recommendations and suggestions for the consolidation and strengthening of the programs and services.

3. Programs' context, origin and content

To begin with, it is important to point out that the programs (Sao Paulo and Mexico D.F.) and the Plan analyzed in this study[85] arise in much different socio-political contexts: in favor of the development of this kind of initiatives in the cases of Sao Paulo and Mexico DF, and quite adverse in the case of Buenos Aires/Argentina.

Both in Brazil and Mexico, the Action Platforms of the Cairo and Beijing Conferences gave political legitimacy to those actions aimed at the adolescent population which were under development both by the health sector and the NGOs.

Starting in the mid '70s, in Mexico the state attached importance to family planning, and influence exerted by international organizations such as PAHO, UNFPA and UNESCO facilitated the development of reproductive health services aimed at the adolescent population.

In Brazil, the existence of a substantial public debate regarding health and sexual and reproductive rights, as well as the dialogue between the civil society and the state regarding the PAISM proposal (Women's Integral Assistance Health Program) in the '80s, facilitated the design and implementation of health programs for adolescents. As shown by the case study, the PROSAD benefited enormously at a local level from the efforts made for the implementation of women's health promotion and care as well as from the existence of an important health movement which stands for the principles of the unified health system (holistic care, universal coverage and hierarchy of services[86]) Both factors legitimated the development of services specifically aimed at the adolescent population. Regardless of these facilitating conditions, the Sao Paulo case's authors point out that there is still not enough sensitivity to adolescents' health

[84] For data for each case, see the respective case studies.
[85] From now on, the term 'programs' will also include the National Plan for the Integral Health of the Adolescent (Argentina) in order to facilitate the reading process.
[86] Implying that the different complexity levels must be organised.

matters among those responsible for the monitoring of public health policies (the health councils). When the National Health Council defined the priority work areas in 1999, adolescents' health and its interface with issues such as drugs and AIDS were not included. Authors attribute this lack of sensitivity partly to scarce articulate action by youngsters who, unlike the women's movement, do not exert any pressure on the state.

In Argentina, instead, the plan arises in a quite adverse political-institutional context: the government of president Menem (1989-1999), which was clearly aligned with the Vatican's position at the Cairo and Beijing Conferences. At both international conferences, Argentina's official delegation supported conservative positions and endorsed restrictions regarding reproductive health and rights and abortion and explicitly acknowledged the right to life since conception.

Another difference among national cases which must be highlighted is that both in Mexico and Brazil international organizations (PAHO, UNFPA, WHO, UNICEF, etc.) have had and still have a higher influence on governmental actions in the field of health care for adolescents and youngsters than in Argentina, due both to their contribution of financial resources and technical support and to their greater presence as social actors in the debate and political action related to this issue[87].

Finally, we can also point out differences in the programs' genesis. Both in Sao Paulo and Buenos Aires the programs were developed based on proposals by professional groups (gynecologists, pediatricians, public health specialists) with experience working with adolescents in public hospitals linked with medical faculties[88]. In Mexico D.F. instead, NGOs with a record of prior work with adolescents actively participated in the discussion of the program's proposal.

Regardless of these differences, both the analyzed programs and the services through which they are implemented share common traits and face similar obstacles or challenges.

The analysis of the programs' contents shows that their main structural ideas are similar:

a) integral health concept (bio-psycho-social);
b) interdisciplinary teams;
c) emphasis on provision of information;

[87] We must point out that Argentina has never been a priority country for these agencies, because it is considered a more developed country than others in the region and because of its early demographic transition.

[88] Interviews in Buenos Aires, and to a lesser extent in Sao Paulo, showed a certain incumbencies' dispute between paediatricians and gynaecologists regarding adolescents' attention. Going deeper into this issue would have implied additional work which exceeded the objectives of this research. However, we think it is worth mentioning it and considering it as a potential research subject for future work.

d) emphasis on contraception;
e) emphasis on preventing teenage pregnancy (seen as the adolescents' main reproductive health problem);
f) development of community based actions;
g) emphasis on the promotion of "responsible" attitudes/behavior regarding sexuality and reproduction;
h) scarce mention of the male's role in reproductive health prevention and care.

Beyond the already mentioned differences in origin, the programs' texts reveal the existence of a common language which seems to respond first to the influence exerted by PAHO and/or FNUAP (according to countries) and second to the fast dissemination of the consensus achieved in Cairo and Beijing.

As it was already pointed out in the Introduction to this study, the language used in the Cairo and Beijing documents reflects tensions among the positions sustained by the main actors involved in the process (international organizations, the women's movement, religious groups). Consensus at ICPD was reached due to the adoption of a very particular syntax, where antithetic positions are juxtaposed and vague, and imprecise concepts and expressions coexist in the text alongside with expressions that restrict the scope of recommendations. The juxtaposition of different languages and perspectives is particularly evident in the sections on adolescent sexual and reproductive health and rights. In particular, as mentioned above, documents place great emphasis on the concept of individual responsibility in relation to sexuality and reproduction and attribute a determining role to information as a means of enhancing such responsibility. It is interesting to note that the emphasis on "responsible" sexual behavior is stronger in the case of those providers interviewed in Buenos Aires and Mexico D.F. than in Sao Paulo. Moreover, the Mexican case mentions that the providers' "intuition" regarding how responsible a teenager is, is one of the criteria upon which the contraceptive method is decided. In Sao Paulo providers seem more conscious of the fact that fostering a sexual subject, an individual capable of being the regulating agent of his/her own sexual life, is a complex process that requires more than information and appeals to responsibility. We believe that both the long lasting sustained action undertaken by the feminist movement and Paulo Freire's influence explain this difference between the Sao Paulo's health professionals perspective and the others'.

Finally, we must point out that it is the "oldest" one of the analyzed programs (PASA, linked to the Sao Paulo University School of Medicine, from 1985) which presents the most

innovative conception. By the mid '80s this group already spoke about "favoring the adolescent's knowledge and autonomy", and has lately developed a work conception which even criticizes the interdisciplinary approach for being a mere union of various perspectives instead of really integrating the knowledge of different disciplines.

4. Obstacles to the implementation and/or strengthening of the programs/services for adolescents

Among the main obstacles to the creation and implementation of programs in Mexico we must mention pressure by the Catholic Church against birth control and sexual education provided apart from the family, as well as the opposition by the Provida group and the National Action Party (PAN).

Also in the case of Buenos Aires city, the lack of a specific program was to some extent the result of the strong influence exerted by the Catholic Church's hierarchy to prevent the provision of information and contraceptive methods to adolescents. Actually, the provision of reproductive health services to adolescents, together with the inclusion of IUDs in the list of contraceptive methods to be provided in public hospitals, was one of the conflictive issues which explain why the National Senate did not approve the reproductive health bill which had obtained partial approval in the Deputies Chamber in 1995, therefore agreeing to the requirements of the Catholic Church.

The Sao Paulo case study also reveals the existence of pressure by the Catholic Church regarding sexual education, contraceptive methods and abortion issues. E.g.: the Catholic Church has taken action to have only those professors trained by it teaching sex education in public schools, and has also exerted pressure on the legislative body (both at the federal and local level) regarding the existence of legal abortion services[89].

In the two cases where programs exist (Sao Paulo and Mexico D.F.) we can see that they are institutionally fragmented. E.g.: even though there was a specific technical and programmatic formulation for the work with adolescents, until 1999 the Adolescents Program was coordinated by the Maternal and Child Health Care Area (either related to women's health or to children's health). Only recently the program responds to a specific area aimed at serving that population group. The PREA (Mexico D.F.) also shows how the programs for adolescents usually remain a part of the maternal and child care area: it is actually one of the multiple

[89] In Brazil, abortion is legal when pregnancy is the result of rape or when the woman's life is at risk. The feminist movement lobbied for the Parliament's approval of a bill forcing the public health system to carry out legal abortions. The Catholic Church actively tried to prevent the bill's approval. The project has been

activities developed by the Baby and Mother Friendly Hospital. The Mexican case study also shows the existence of problems found in Buenos Aires as well, and in Sao Paulo to a lesser extent: there is practically no link between the different state and federal agencies that carry out activities related with teenage health services in the DF, nor between the primary and secondary care levels. Something similar happens in Buenos Aires, where there is no coordination between those activities aimed at adolescents developed in health centers (as part of the Responsible Procreation Program, which provides information and contraceptive methods to the general population) and those developed in Adolescent Services in public hospitals.

The study also shows the existence of obstacles for the implementation and consolidation of health programs for adolescents, related to: a) the adverse socio-economic situation of vast population sectors in all three countries (high unemployment rate, growing poverty levels) and b) the contraction of public sector participation in the provision of health care and/or the deterioration of the quality of the services provided. As a result of the health sector's reform we can observe staff reductions, absence of new hiring, and cutbacks in the health budgets. The Sao Paulo case shows that this scenario highly obstructs the constitution of teams at a central administration level aimed at stimulating health programs for adolescents through technical and administrative support. Without such stimulus from the central administration, those local teams which succeed to continue their activities become isolated experiences.

In the three cases the service providers report similar concerns regarding the amount and profile of the patients they serve. According to testimonies obtained in the interviews, access of those patients with less resources has been greatly affected in the last years (e.g.: patients who have stopped attending the health center or hospital because they cannot afford transportation). Additionally, all sites report that the clientele's profile is changing. More and more often they serve middle class patients who lost the health coverage they used to have through the job market. Some of the persons interviewed stated that they find it easier to work with these new patients, more educated and with higher economic resources. As regards the amount of consultations, testimonies indicate that it has increased in the last years[90].

Another demand shared by all three sites is the need for more human resources, and, particularly in the case of Mexico D.F., for human resources adequately trained to work with adolescents. In some cases there have been drastic staff reductions, while in others the reductions weren't abrupt but will be evident in the mid and long term, because those professionals who retire are not being replaced by new ones. Regarding the "type" of human

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filed away, but there is a regulation by the Health Ministry which authorises this procedure and establishes conditions for the installation of legal abortion services by the SUS.

resources which should be appointed to improve the services, we found differences: while the Sao Paulo study shows the lack of professionals in many specialities (even general practitioners), in the Buenos Aires service there's deficit in the nursing area[91].

Also, as the result of the reduction of funds in the health sector, working hours have been reduced. As shown in the case studies, the reduction of personnel and/or working hours has seriously affected the health team's possibilities of developing preventive and/or outreach community oriented activities. In two of the six services studied (Argerich Hospital in Buenos Aires and PAM M. Zelia in Sao Paulo), the professionals' "nostalgia" for bygone days in which they could develop intense community work because they had enough staff and/or external resources (e.g. a Kellogg Foundation allowance) for such activities was evident. In the Mexico D.F. study, community work is recent, non systematic and less important than the intense health care work developed by the "module". There is no community work in the case of PREA.

Work overload has also affected the staff's chances of attending training courses. The Mexico D.F. study provides a good example of such situation: in Iztapalapa the new director banned the module's personnel from participating in the GIRE network by arguing that services cannot afford to stop providing care during the network meetings.

Lack of personnel also results in professionals both attending adolescents and fulfilling other functions within the institution (e.g.: the Ma. Zelia nurse in Sao Paulo also attends persons with high blood pressure and/or diabetes, sterilizes the unit's instruments, etc.).

Other obstacles to the adequate provision of services in all three cases are the lack of supplies –particularly contraceptives- and the problems related to lab studies. Many of the professionals interviewed stated their limited possibilities of prescribing lab studies due to either cost problems or to the delay in the handing over of results, which in turn affects service provision (e.g.: IUD placement). In the Buenos Aires case, interviews showed that patients who have medical coverage usually use its lab services as a strategy to avoid the delay in results'handing over at the public hospital. In Sao Paulo, where there are quotas for the number of lab studies that can be required by the health units, patients face the alternative of either waiting a long time before they obtain the studies or paying for them at private labs.

Finally, the study allowed identification of a series of obstacles and/or challenges for the programs and services specifically inherent to work with adolescents in the reproductive health field.

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[90] In Buenos Aires, where we had access to the Health Service Statistics, we can observe that between 1994/5 and 1998 the amount of consultations increased in one of the services and decreased in the other one.

One of the distinctive features of adolescent health care provision is that they usually require longer visits than adults and that providers need to have the ability to "read between the lines" to identify latent reasons for consultation underneath the explicit ones. Two of the services (one in Buenos Aires and another one in Sao Paulo) specified that teams work based on the idea that an adolescent's visit to a health service should not be a "lost opportunity", which results in longer consultations than in the case of other specialities. Various interviewees indicated that many times this specificity is not understood in health institutions, particularly given the growing concern of officials and administrators regarding the services' productivity. On the other hand, sustaining this principle is also difficult due to the work conditions earlier described, and may result in tensions with other professionals who must deal with a higher amount of consultations per working hours (as reported in one of the services in Mexico D.F.).

There is broad consensus among experts and health professionals regarding the benefits of interdisciplinary work when serving an adolescent population. Our research indicates that to look for the integration of the various types of knowledge and visions is not an easy task. We believe it is necessary to further inquire into it and give thought to it in order to develop more adequate programs and services. Sometimes these difficulties were clearly expressed as a "problem" which the interviewed persons should solve by themselves (Mexico D.F., for instance). In other cases there were no explicit references to the need of improving interdisciplinary work, but these became evident while discussing specific subjects such as "dual protection", on which psychologists and physicians held opposite perspectives at the services studied in Buenos Aires. However, our research reveals interesting efforts to move ahead towards interdisciplinary work. One example is the mechanism of joint admission by a physician and a psychologist at the Hospital Rivadavia in Buenos Aires. Another one is the existence of a single medical record for each patient, in which the notes and insights provided by the different health providers enhance the team's ability to better understand patient's needs and demands (Butantá, Sao Paulo). These are undoubtedly auspicious experiences in contexts in which the prevailing culture still emphasizes the curative paradigm rather than stressing prevention activities, and assigns differential values to the different health professionals' knowledge (doctors, nurses, psychologists, educators, social workers).

Another aspect to be considered when working with adolescents is the fact that because this age group has a legal status different from that of adults, health care providers many times feel helpless against eventual legal actions which parents or tutors might initiate. In this sense,

[91] These differences are obviously related to the peculiar human resources structure of each health system. E.g.: in Argentina the lack of nurses has historically been a serious problem.

the studied situations are clearly different. In Buenos Aires, given the lack of a program or common regulation, health professionals clearly expressed their fear of being sued or sanctioned for providing contraceptive methods to adolescents. In Sao Paulo this matter was not mentioned as worrying at the studied services, but it is indeed a concern for other professionals from that health care network as found along different activities held by the research team with health providers. In Mexico D.F., regulations were modified in 1994 to explicitly include the adolescents' right to request and receive contraceptive methods, therefore granting more security to doctors. Although giving or prescribing contraceptives to adolescents was not prohibited before 1994, the lack of legal regulations on the subject inhibited many physicians, who feared legal demands or sanctions for such a practice.

Given the fact that abortion is illegal in all three countries, health professionals face difficulties when trying to responds to adolescents' demands and to offer them proper orientation. However, there seems to be different attitudes among the providers interviewed in Buenos Aires and Sao Paulo and those interviewed in Mexico D.F.. In the first two cases, they are usually more explicit when talking about conditions for safe abortion and the need for patients to return to the service for post-abortion control.

Difficulties to deal with violence and addiction issues can be observed at the three sites. Even in cases such as Butantá, Sao Paulo, where the staff is highly aware of the prevalence of violence against women and has been trained to deal with this issue, professionals state that the violence-drugs interface in the adolescent population is a highly complex matter. In general, the studied services tend to derive these cases to specialized institutions.

The promotion of "dual protection" (giving advice and providing contraceptive methods to avoid unwanted pregnancies and sexually transmitted diseases) can be considered either a services' deficit or an activity difficult to implement due to different reasons. In the case of Sao Paulo, it is mostly due to lack of resources: even if professionals are aware of both problems, they said that the lack or discontinuity of male and female condoms hinders the possibility of sustaining such a policy. In Buenos Aires there are different attitudes among physicians and psychologists: physicians seem more convinced than psychologists of the fact that "dual protection" is really difficult to implement due to psycho-social and cultural reasons, and out of the "two risks" they tend to privilege pregnancy prevention. Surprisingly, in Mexico none of the two studied services works on "dual protection", even if theoretically there should be a clear articulation between the reproductive health program and the HIV/AIDS one.

Health professionals show different degrees of familiarity regarding the gender and reproductive rights perspective. The Mexico D.F. study shows that the Cairo and Beijing

recommendations were known at best by mid level officials. Most providers have no knowledge of international agreements whatsoever, and have not been informed/trained on this subject. In the case of Sao Paulo the situation is different. It is a context in which there has been a broad discussion regarding women's rights, particularly sexual and reproductive rights, due to articulate action by the women's movement. In the services studied in Buenos Aires, professionals were more familiar with the gender and rights perspective than other colleagues working at Ob-Gyn services in the city's public hospitals[92]. However, there was heterogeneity in the degree of knowledge and acceptance of the gender and rights perspective in the field of reproductive health and sexuality among health professionals interviewed in this city. To conclude, it is an auspicious fact that in all three sites most of the interviewed professionals agreed with the idea that health services are responsible for promoting users' self-esteem and autonomy.

5. Work facilitators in adolescent reproductive health

In all three cases it is evident that health teams are formed by people with a great motivation and commitment for work, and also that to a great extent the programs/services survive thanks to these professionals' efforts. Despite the precarious conditions in which they work, health professionals are personally (and politically, in the case of Sao Paulo) committed with the duties they develop. Such commitment can be seen in their efforts to obtain free medicines and supplies (contraceptives, among others) and refer patients to specialists that are sympathetic to adolescents as well as in their flexibility to perform tasks which exceed those they were hired for. This is particularly evident in the case of Sao Paulo, but it is also common in the other two sites. We must also point out that in the three cases the providers interviewed mentioned satisfaction derived from the work with adolescents as a factor which facilitates their job. Some of the most mentioned satisfaction motives were: a) participating in a work team, which implies theoretical and technical affinities and sharing decision-making with other colleagues; b) finding out that their work has had a positive impact over time. E.g.: at the PAM Ma. Zelia (Sao Paulo) they indicated that adolescents served by the program participate more at school, have less rebellious attitudes and show a better performance, etc. At the Rivadavia Hospital (Buenos Aires) the interviewed providers report the fact that requests for contraceptive methods are now the top rated consultation reason as one of the program's achievements. In Mexico D.F. providers think that their job has had a positive impact because adolescents return

[92] According to the results of a survey developed by the CEDES team with Ob Gyn in all the city's public hospitals, only two out of each ten people interviewed had heard about gender studies (Ramos et al,

to the service after giving birth to request a contraceptive method. Patients' thankfulness was also reported as a major incentive to continue work in adverse conditions (Hospital Argerich, Buenos Aires).

6. The users' perspective

In general the interviewed adolescents showed satisfaction for the services they received. The main criticisms are related to long waiting hours, the method for assigning turns and/or the facilities. The relationship with care providers is evaluated in a very positive way in most of the cases: adolescents show satisfaction for the treatment and explanations received, and for the service being free of charge. Both in the cases studied in Mexico DF and in Buenos Aires women teenagers expressed their preference for receiving health care from a professional of their same sex. In the three sites unwanted pregnancies and HIV/AIDS are the main concern of the adolescents interviewed. Violence (be it urban, familiar and/or sexual) and alcohol/drugs use are not perceived as health related matters nor as a health services' incumbency by most of the interviewed teenagers.

7. Conclusions and Recommendations

Each of the case studies presented includes conclusions about the programs and services analyzed, as well as specific recommendations on how to strengthen and improve them.

In this section we will present the main conclusions and recommendations common to the three case studies as well as some reflections about the adequacy of these programs and services to the recommendations contained in the Cairo and Beijing Platforms.

The first conclusion to which we arrived, is that a strong tension exists between programs' goals and objectives (primary prevention, provision of health care services from a bio-psycho-social perspective, community work, among others), and the economic and social conditions under which the services and programs in the three cities currently operate. We believe that the study conclusively illustrates that the consequences of structural adjustment policies and health sector reform (higher number of population without medical coverage due to increasing rates of unemployment, drastic cuts in public resources allocated to health expenditures, reduction of health care personnel and shortage of medical supplies) hamper the implementation and consolidation of quality holistic health care services for adolescents.

2000).

Despite the unfavorable conditions, the programs and services have subsisted throughout time or have started to develop due to the influence of the international agreements signed by the governments, and fundamentally due to the individual commitment and the perseverance of professional groups highly motivated to provide health care to adolescents.

The study reveals that, despite the differences mentioned above, the analyzed programs and services face some common problems. It is important to note that in some cases some of those problems have been clearly identified as deficits of the programs or services either by the health care providers or the users interviewed. In other cases, they constitute deficits or challenges related to the Cairo and Beijing guidelines, which program documents follow in greater or lesser extent depending on their starting date (some of the programs were written prior to Cairo and Beijing).

First, it is worth highlighting that even though the rights to reproductive health of adolescents are gradually being realized, socio-cultural and religious barriers still affect the promotion of adolescent sexual and reproductive health rights in the three sites.

Secondly, the study also illustrates the existence of different types of obstacles to the effective implementation of holistic or integral health care. These obstacles are mostly related to the lack of resources (financial and human) but also to the culture and dynamics of health institutions, the training received by the health care personnel, and in some cases, even to the expectations and attitudes of the user population.

We also observed that, despite its goals, programs have an eminently curative approach and that they only reach a small percentage of their target population. The health care providers interviewed consider that developing community activities and articulating actions with other governmental agencies (in the fields of education and employment for example) and with NGOs could contribute to reduce those deficits. However, such activities do not seem to be a feasible alternative in the short term, given the working conditions described above.

Another conclusion of this study points out the need to train or re-train health care personnel on topics such as adolescent issues, socio-cultural aspects of the health-illness process, gender, and sexual and reproductive rights[93]. As proposed in one of the case studies, we suggest that the main goal of providing training in the gender and rights perspective should be to enable health care teams to translate these principles (gender equity for example) into systematic actions to be applied within the services.

[93] It is important to note that this need seems to be greater in some places than in others.

Training should also be focused on strengthening and developing health professionals abilities to deal with issues such as induced abortion, dual protection, emergency contraception, violence and substance abuse.

The study also points out that programs' evaluations are nearly non existent, and that when they exist, their results are not widely available. We consider that program monitoring and evaluation are pending tasks which could contribute to strengthen the programs and reorient their actions. If the political will and the necessary resources to carry out such evaluations were available, it would be important, as mentioned in the programs' written documents, to include the participation of adolescents. This is an item where a great gap exists between programs' experiences and the recommendations of international meetings that acknowledge the need for the participation of adolescents of both sexes in the design, implementation, monitoring and evaluation of activities that concern them, in order to ensure that action is effective and appropriate to local cultures (UNFPA-ICPD+5, 1998, p.22)

Another difference observed regarding the Cairo and Beijing guidelines is that the adolescents services studied tend to reach almost exclusively female population. In that sense, it could be said that the objective to promote male responsibility in sexuality and fertility proposed in the Platforms of Actions is not being achieved. However, as accurately pointed out in the Sao Paulo study, incorporating males to the reproductive health services under the current conditions would require to overcome different types of obstacles. In one hand, males do not come to the services because such services are identified as "female services" (the majority of health professionals and patients are women, and reproduction is culturally identified as a female domain). On the other hand, the services are not prepared to think about and respond to the eventual needs of boys, who will probably demand attention to questions yet little explored, or difficult to deal with, such as those associated with drug abuse and/or violence. We find this an issue that deserves reflection and further research.

To sum up, many constraints remain to be overcome to effectively address adolescents health care needs, particularly in the field of sexual and reproductive health. However, research findings suggest that progress has occurred since the mid-70s when some pioneers in our region envisioned programs and services that would meet the needs of adolescents, specially of those from disadvantaged groups. We hope this study has contributed in some way to expand knowledge on existing programs and services that have a high commitment to develop actions that protect and enhance adolescent sexual and reproductive health.

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GENERAL ANNEX

THE FUTURES GROUP INTERNATIONAL

Reproductive Health Programs for adolescents. The cases of Buenos Aires, México D.F. and Sao Paulo.

INTERVIEW GUIDELINE FOR PUBLIC OFFICALS[94]

1. The program, its goals, strategies and development.

- Date of program creation
- When the implementation of a program for adolescent sexual and reproductive health was considered a necessity? Why?
- Date the program actually began operating
- General idea behind the program
- Primary objectives the program seeks to achieve. Short, middle and long term goals. Reasons for each of them.
- Main strategies implemented in order to achieve program objectives and goals (health care services; mental health services; information, education and communication strategies; within the services, in the community, in schools, etc.)
- Placement of the program within the public administration structure
- Program resources and funding (origin, amounts, autonomous budget or not).
- Program users' characteristics (age, sex, social class, education, marital status, sexually active, virgin, employed, student, etc.)
- Number of high-rank personnel involved in the program. Functions each of them carry out. Existence of board of consultants or interinstitutional committee. Functions they carry out.
- Existence of specific regulation (direct or indirect) for integral adolescent care. If not, ask why it does not exist and if they have plans to develop such regulation.
- Existence of legal norms that could influence adolescent care.
- Significant changes in program development (continuity, disruptions, factors which conditioned such changes).
- Program implementation in health services (levels and ways in which it operates: through modules, clinics, ambulatory care). Participating professionals; functions each of them carry out.
- Program implementation in the community (through modules, ambulatory care, lectures, home visits). Idea of what “contact with the community” should be. Links and cooperation with other institutions (educational, politic, religious, civil, parent organizations, NGO´s).
- Links with other state dependencies: collaborative actions between sectors.
- Adolescent participation in program formulation, design and evaluation. Reasons why.
- Conferences of Cairo and Beijing. Knowledge about the main recommendations and level of impact on the program.

2. Health care services for adolescents

- Type of health care services offered by the program
- Program target population

[94] Guidelines were developed with inputs from Miller, R. et al, 1997. *La estrategia de análisis situacional para la evaluación de servicios de planificación familiar y salud reproductiva. Manual*. Proyecto de Investigación Operativa y Asistencia Técnica para Africa. The Population Council. México. Language was adapted in each site as appropriate.

- Specific actions and means used to reach out adolescents (media, educational materials, videos, lectures). Service promotion and publicity (within the health care services, in the community, in schools, others).

3. **Adolescent sexual and reproductive health care (from the program perspective)**

- Main health problems affecting adolescents (their view, personal opinion) and main problems regarding sexual and reproductive health.
- How are adolescent sexual and reproductive health needs detected
- Characteristics of adolescent sexuality and reproductive behavior (attempt to identify particular characteristics, similar and/or different between males and females).
- Adolescent pregnancy. Has this phenomenum increased? Causes and consequences of adolescent pregnancy. Does he/she perceive differences among different social sectors? Adolescent motherhood/fatherhood.
- Abortion as an important adolescent women´s heath problem. Why? Is this practice increasing? Why?
- AIDS in the adolescent population
- Main factors that encourage and/or discourage adolescents´ contact with sexual and reproductive health services.
- Opinion on how the State is resolving adolescent population´s access to contraception.

4. Health personnel selection and training

- Profile required in health care professionals working in health care services for adolescents (age, sex, profession, etc.). Selection mechanisms.
- Training received (before entering the service, ongoing training, timing and duration of training, who defines training course curricula; knowledge and technical skills acquired; evaluation of the knowledge and technical skills acquired). Are there differences by profession?

5. Program evaluation

- How would you evaluate the impact that the program has had on the adolescent population up to this moment? (program in general, its general and specific goals, its main strategies). Criteria used to evaluate program achievements.
- Obstacles the program faces (political, institutional, ideological, sociocultural, personal, etc.).
- Areas in which the program has achieved best results. Why?
- Program evaluation. Yes, no, why? Who will evaluate or evaluated (internal or external)? Criteria followed, scope, type, frequency and results).
- Supervision of health care services. Who supervises, criteria followed, scope, type, frequency and results).

TO FINISH I WILL READ SOME STATEMENTS. PLEASE TELL ME IN EACH CASE WHETHER YOU

- AGREE
- DISAGREE
- DON´T KNOW...

1. Men are naturally more prone to risky behavior than women.

2. Female adolescents are more exposed to HIV/AIDS than men because they have less decision power regarding condom use.

3. Promoting users' self-esteem and autonomy is not a responsibility of the health care services.

4. Fertility regulation is a prerogative of every individual.

5. A woman does not have the right to use a contraceptive method if her partner does not agree.

6. The decision to voluntarily interrupt a pregnancy is ultimately the woman´s attribution.

6. Program perspective and future

- Future plans or actions (changes, program expansion or reduction, etc.) Grounds on which such actions are foreseen. Evaluations planned (what will be evaluated, who will evaluate, how will the evaluation be carried out).

THE FUTURES GROUP INTERNATIONAL

Reproductive Health programs for adolescents. The cases of Buenos Aires, México D.F. and Sao Paulo.

INTERVIEW GUIDELINE FOR HEALTH CARE PROVIDERS

1. Profile of the population they serve

- Characterize the population that comes to this service (include socioeconomic status, age, education, marital status, family group conformation, employment).

- Which adolescents come to this service and which ones do not come? Why? More females or more males? Has this changed over time or has it been constant? Perceived differences among the adolescents who come to the service. Perception of how the adolescents' social context influences their health.

2. Service profile and activities performed

- Describe a typical day of work since you arrive until you leave

- Ask about the conceptualization of health that the service has.

- What do you understand for adolescent integral health? What do you understand for adolescent sexual and reproductive health? (Explore if it is possible to identify a shared position or differing views among professionals in the work team).

- Is there an obligation to require parental authorization in the cases of minors needing some type of medical intervention? (If yes ask the next question)

- How does the service handle the adolescents who come by themselves?

3. Human resource training

- Acquisition of knowledge and technical skills related to sexual and reproductive health and adolescence (during undergraduate or graduate education or in special courses) Type of knowledge and skills acquired. Duration of training. Does he/she consider that the acquired knowledge and skills help or limit his/her practice with these patients/users.

4. Reason for medical visit

- What are the most frequent reasons for medical visit? Specify manifest and hidden reasons.

4.1. Contraceptive methods

- Different strategies used to encourage use of contraception in males and females.

- Factors which facilitate and/or hinder contraceptive use in adolescents.

- Criteria followed to recommend a contraceptive method.
- Do you provide information about all existing methods or only about those available in the service?

- How do you combine in your daily work these two main issues for adolescents: contraception and STD and HIV/AIDS prevention?

4.2. Pregnancy

- Services offered to pregnant adolescents (prenatal checkups, delivery, postnatal, etc.). If they do not offer any of these services: Where do they refer those patients and why?

- Partner, peer or family participation in pregnant adolescent care. What meaning does this have in terms of the process that the adolescent herself is going through?

4.3. Sexual education

- Does the service offer information or counseling regarding sexuality?

- Do you offer group activities or talks that allow young people to ask questions or debate about sexuality?

- What is your perception of the impact that this type of work has had?

- Is sexuality approached in a different way with males and females? Why?

4.4. Violence

- Explore whether or not violence is perceived as a health problem and why.

- If the answer to the above question is yes ask how they handle adolescents with violence problems.

- Are they referred to other institutions? Which institutions? What cases are referred?

- Do you propose that parents, other relatives or peers get involved? Why?

- Do you carry out preventive work (within the service/in the community).

- Specify type of violence (urban, domestic, sexual).

4.5. Drug abuse, alcoholism and other addictions

- Try to detect whether substance abuse (alcohol, drugs) is perceived as a health problem or not and why.

- Description of the population with regards to this issue. How is it detected.

- Do you propose that parents, other relatives or peers get involved? Why?

- Do you carry out preventive work (within the service, in the community).

4.6. Abortion

- In cases of unwanted pregnancy, what attitude does the service assume?

- What can the service offer in cases of unwanted pregnancy? (abortion, referrals, psychological support

- Consequences of an abortion experience for males and females; In particular for each sex, similarities and differences.

5. Relationship with the community

- Do you have any type of relationship with community organizations?
- What kind of work do you carry out together?

- Do you work with other community institutions in adolescent problems detection and prevention? Which ones?

- What have been the major difficulties in working with the community?

6. Health providers´ satisfaction with their own professional practice

- Factors that hinder the achievement of proposed goals in your daily work (legal, economic, political, human resources, institutional, organizational).

- Factors that facilitate the achievement of proposed goals in your daily work (legal, economic, political, human resources, institutional, organizational).

- Detect level of satisfaction regarding the relationship between their professional practice expectations of the actual possibilities to achieve such expectations (human resources, infrastructure, users´ profile).

7. Perception of adolescents' satisfaction

- What are the main needs and demands expressed by adolescents in the service. To what extent are they fulfilled?

- What are some of the demands made by adolescents that cannot be fulfilled? Why?

- What are the main complains that adolescents have regarding the type of services offered? How could the services that are offered be improved?

8. Gender perspective

TO FINISH I WILL READ SOME STATEMENTS. PLEASE TELL ME IN EACH CASE WHETHER YOU

- AGREE
- DISAGREE
- DON´T KNOW...

1. Men are naturally more prone to risky behavior than women.

2. Female adolescents are more exposed to HIV/AIDS than men because they have less decision power regarding condom use.

3. Promoting users´ self-esteem and autonomy is not a responsibility of the health care services.

9. Rights

1. Fertility regulation is a prerogative of every individual.

2. A woman does not have the right to use a contraceptive method if her partner does not agree.

3. The decision to voluntarily interrupt a pregnancy is ultimately the woman´s attribution.

THE FUTURES GROUP INTERNATIONAL

Reproductive Health programs for adolescents. The cases of Buenos Aires, México D.F. and Sao Paulo.

INTERVIEW GUIDELINE FOR USERS OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES.

1. Link with the service

- How did you find out about this service?
- Do you know other services? Why did you choose this one?
- How long have you been coming to this service?
- If you could choose, which would be the most convenient time for you to come here?
- Do you feel that the waiting time was reasonable or too long?
- How do you get here (means of transportation)? How long does it take you to get here?

2. Reason for the visit

- Why did you come here today?
- Did you come alone or somebody came with you? Why? Who came with you? Did your partner ever come with you? If no: Why your partner never came with you?
- Besides the reason why you came here, were you offered any other type of health care service by the health care provider? What other services did you receive?

3. Satisfaction with the visit

- Did you feel that you received the information and the services that you required? Yes or no, why?
- Did you feel that you learned something new or that you could clarify any doubts you had? Why?
- Did you receive more information than you demanded?
- Did the health care provider listen to your concerns?
- Did he/she let you ask questions?
- Did the provider use a clear language that allowed you to understand what he/she said?
- Did any doubts or questions remained unanswered? Which ones?
- Did the provider tell you when you have to return?
- Do you prefer to receive health care from a female doctor or a male doctor? Why?
- (In cases where payment is required): What is your opinion regarding the total cost of the service? (expensive, a little expensive or acceptable)?
- Have you recommended or do you think you would recommend this service to a friend of yours? Why?
- Do you think that a friend of yours with any of the following problems would come to this service?

1. Interest to talk about sexuality, 2. Counseling on unwanted pregnancy.
3. Contraceptive information and supply, 4. HIV counseling and test.

- Do you have any suggestion to improve the services that are offered in these facilities? Which one/s?

4. Privacy and confidentiality.

- Were other people present during the visit besides the health care provider?
- Did anybody explain to you what the exam was about before performing it? Did the health care provider explain to you the results of the procedures or exams?

- How did you feel during the visit?

5. Information, education and communication activities

- If information brochures are available: Did you take one? Did you read it? Did you offer it to other people? What do you think about it?
- What was the brochure about?
- Did you ever participate in the information groups? Did you like it? Do you think it helped you to learn more or to better understand things that happen to you?

6. Pregnancy, knowledge about STDs and HIV/AIDS.

- What do you think are the most important health problems of the people your age? (If he/she enumerates take note of the order and ask how he/she would resolve each of the problems if they affected him/her).

  If he/she does not enumerate problems then mention:
  Pregnancy
  Abortion
  AIDS
  STDs
  Violence (sexual, domestic/family, urban)
  Drugs
  Alcohol

- Do you know of any networks or strategies outside this service that could help solve these type of problems?

- Does anybody in your family know that you come here? Who? What does this relative think about you coming to this service?

7. Personal information

- Age
- Marital status (including if he/she has a steady partner or not)
- Place of birth
- Place of residency
- If migrant: How long have you been living here?
- Number of children. Ages of the children
- Highest level of education attained
- Do you practice any religion? Which one? Do you think that your religion affects the decisions you take regarding your heath.
- What do you do for a living? How do you obtain the money you need for health care?

INFORMED CONSENT FORM FOR PROVIDERS/PUBLIC OFFICIALS INTERVIEWS

Reproductive Health programs for adolescents. The cases of Buenos Aires, México D.F. and Sao Paulo.

The Center for the Study of State and Society (CEDES) together with the Colegio de México from Mexico City and the NEPO (University of Campinas) from Brazil, are carrying out a study about the programs and plans related to adolescent reproductive health. The goal of this research project is to study the factors that facilitate and/or hinder the development and implementation of reproductive health programs for adolescents, and to know the opinions and attitudes of the medical teams and the adolescents with regards to this matter.

As part of this study we are carrying out a survey with public health care providers in order to find out their experiences and opinions about the topics mentioned above. The survey will be carried out by research team members; it will last aprox. 40 minutes and it will be applied at a time of your convenience.

The information collected during the interview will be strictly confidential: The interviewer will not reveal the content of this conversation to anybody except other researchers participating in the study.

You have the right not to accept the interview. Also, if you accept the interview you have the right not to answer any question you might consider inappropriate or to interrupt the interview at any time.

We wish that the information kindly given by you will be useful to detect adolescents´ specific needs and help in program design as well as in the improvement of the quality of care offered in these services.

If you have any doubt or concern regarding this project please contact:

.....
(Name of principal researcher in each site)

.....
(Name, address and phone numbers of Institution in each site)

INFORMED CONSENT FORM FOR USERS´ INTERVIEWS

Reproductive Health programs for adolescents. The cases of Buenos Aires, México D.F. and Sao Paulo.

The Center for the Study of State and Society (CEDES) together with the Colegio de México from Mexico City and the NEPO (University of Campinas) from Brazil, are carrying out a study about the programs and plans related to adolescent reproductive health. The goal of this research project is to study the factors that facilitate and/or hinder the development and implementation of reproductive health programs for adolescents, and to know the opinions and attitudes of the medical teams and the adolescents with regards to this matter.

As part of this study we are carrying out a survey with adolescents users of public health services in order to find out their experiences and opinions about the topics mentioned above. The survey will be carried out by research team members; it will last aprox. 40 minutes and it will be applied either before or after the medical exam according to your convenience.

The information collected during the interview will be strictly confidential: The interviewer will not reveal the content of this conversation to anybody except other researchers participating in the study.

You have the right not to accept the interview and this will not affect in any way the medical care you will receive. Also, if you accept the interview you have the right not to answer any question you might consider inappropriate or to interrupt the interview at any time.

We wish that the information kindly given by you will be useful to detect adolescents´ specific needs and help in program design as well as in the improvement of the quality of care offered in these services.

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